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ABSTRACT

The needs of women and the content of existing information programs concerned with drug and alcohol abuse and general health were investigated through a nationwide Alliance of Regional Coalitions on Drugs, Alcohol, and Women's Health sponsored by the National Institute on Drug Abuse. Results indicated that: (1) multi-substance abuse is common, but few programs deal with it; (2) substance abuse problems among women have not been documented adequately; (3) a federal interdepartmental task force is needed to focus on these problems; and (4) delivery systems for comprehensive and cost-effective health care services are necessary. (Author/HLM)

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PUBLIC HEALTH SERVICE
National Institute on Drug Abuse
ALCOHOL, DRUG ABUSE, AND
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FINAL REPORT

ON

DRUGS, ALCOHOL AND WOMEN'S HEALTH

AN

ALLIANCE OF REGIONAL COALITIONS

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BACKGROUND: NEW CONCERNS FOR WOMEN

Beginning in 1972, major national conferences on drug abuse began to include issues with social implications on their previously all-scientific agendas. As a result, various special interest groups were formed, among them groups concerned about women with drug abuse and alcohol problems.

In the ensuing years, these groups aired their concerns before any available forum. Their evidence was indisputable; the affected female population was growing.

By 1975, their presentations before city councils and state legislatures and their efforts within treatment programs began to have an impact. People began to recognize that women did have special needs and special problems that were not being addressed by existing efforts.

At the Federal level, these problems of women were gradually given visibility through the efforts of Alberta L. Henderson, then director of the Program for Women's Concerns at the National Institute on Drug Abuse.

In October, 1975, the first National Forum on Drugs, Alcohol and Women in Miami focused nationwide attention on the issues. Participants from all over the country attended the forum to discuss the various problems with unique implications for women. The forum was sponsored by NIDA, through a contract with the National Research and Communications Associates (NRCA), a Washington-based consulting firm.

Drawn from the proceedings, a Source Book was printed. Its contents attest to the scope both of the participants' insights and of the issues themselves, touching on everything from planning and legislative issues to prevention, education, and research.

Despite the diverse perspectives represented, there crystallized among participants a commitment to search for remedies. A voluntary network of five regional coalitions evolved. Within these coalitions, members--some from public agencies, some from private groups--began to communicate on an informal basis, discussing common problems and searching for solutions.

The cumulative effect of the local efforts, plus the Congressional initiatives of Representatives Peter W. Rodino, Jr., and Paul G. Rogers and Senator William D. Hathaway created an atmosphere of promise, particularly when P.L. 94-371, signed into law in July, 1976, included a mandate for the official recognition of the special needs of women and assured new administrative and program initiatives.

In March, 1977, NIDA decided to reactivate and rejuvenate the existing, though rudimentary, voluntary coalitions, strengthening them to form a nationwide Alliance of Regional Coalitions on Drugs, Alcohol and Women's Health. Through this Alliance, NIDA hoped to gather information about existing programs for women, and about perceived needs, and to learn what suggestions Alliance participants could make for

future NIDA activities on behalf of women. NRCA was awarded a follow-up contract to serve as national coordinator for the expanded project.

What follows is a review of the eight-month process during which the Alliance produced, for the first time, a multi-disciplinary public and private sector response to the government's "need-to-know."

Since this was a pilot undertaking to solicit "grass-roots" advice, nationwide, the report should not be construed as scientifically definitive. The results, however, are significant. For despite geographic differences, a synthesis of the independently developed state reports revealed a striking concensus, both of observed problems and subsequent recommendations. In many instances, definitive policy directions can be drawn, relating to information, research, program, and legislative requirements.

Perhaps even more importantly, though, this short-term intensive effort successfully engaged the time, energy and attention of literally thousands of concerned citizens. It also captured the active support of the White House, senior members of Congress and representatives of three executive departments and seven agencies, as well as the leadership of 28 major national organizations.

To achieve this, techniques were developed so that communities could describe how they perceived their own problems and how best the government could respond, rather than

the traditional other way around. These techniques, and the insights gained from the project, provide a model for involving citizens in the development of policies and services. In this instance, by strengthening the local networks, the base of both human and material resources was broadened, increasing initiatives for local determination and cooperation, and lessening the degree of dependency on the Federal government.

ORGANIZING STRATEGY--OVERVIEW

The Alliance was created for the following official purposes:

- To identify the availability of services and resources for women with alcohol or drug dependencies;
- To identify gaps in existing services and resources;
- To make recommendations for change;
- To develop techniques to achieve continuing coordination and cooperation among regional, state and local groups.

The objectives, in themselves, were not unusual. The approach for meeting them was, since, within the loosely organized national group, initiative and responsibility for meeting the objectives was placed at the regional and state levels.

The five Regional Coalitions--each formed of two contiguous Health, Education and Welfare (HEW) regions--developed at the 1975 Forum and served as the core of the network. A Coordinator was appointed for each region and Captains were appointed for each state. To encourage

creative approaches and the development of suggestions relevant to each region, Coordinators were acquainted with the overall goals and objectives of the project but were not restricted by tightly structured directives or an imposed, monolithic organizational framework.

Each region received a basic budget of $4,000 to cover communication, duplication, meeting, clerical/professional, and local travel expenses. These funds were supplemented by NRCA, as costs, travel or product development requirements warranted. NRCA staff developed voucher guidelines and procedures, but each Regional Coordinator was given responsibility for securing services and disbursing funds.

Given the breadth of the problem to be surveyed, Alliance members were encouraged to develop a comprehensive strategy--reaching both public and private groups--for gathering their information and preparing their reports. In response, members contacted and involved a broad range of more than 900 human and social service agencies and organizations, in addition to drug, alcohol, and health professionals.

State captains were encouraged either to use existing state structures, such as task forces, which would remain autonomous but could be strengthened through participation in the Regional Coalition, or to develop state networks if

none existed. Depending on the circumstances, both approaches were used.

Regional Coordinators were urged to assist the State Captains to develop the broadest possible base of support, with the intention of creating a continuing and mutually supportive network of interested groups.

The bridge between the regions was provided by NRCA through its role as National Coordinator. Individual regional initiatives, common problems and solutions were shared with members by NRCA staff through correspondence, telephone communications, and during meetings held within each region. Coordinators were invited to present their findings and recommendations at a concluding Symposium, held in Washington, D.C., in September.

Advisory Council

In addition to the Regional Coalitions, an Advisory Council was formed with members from public and private sector agencies as well as organizations that had nation-wide constituencies. The purpose was two-fold:

1. To inform Alliance members of Advisory Council resources and programs through constituencies at the state and local levels; and

2. To inform Council members of Alliance activities, findings, and recommendations to gain support and promote common purpose.

The criteria for participation on the Advisory Council were :

1. an interest in women's health issues;
2. a willingness to inform constituents of the Alliance's activities; and
3. a commitment to encourage participation with members at the state level.

Council members provided information or assistance either through NRCA or directly to regional or state members.

A preliminary meeting of the Advisory Council was held in March, at which time 13 organizations and agencies that had continued interest since the 1975 conference were invited. Twelve were willing to serve on the Council and to advise and assist the Alliance. By the time the first full Advisory Council meeting was held in June, membership had increased to 36. So that concerns of special populations would also be covered, organizations representing Native Americans, Latins, Asian-Americans Blacks, legal offenders, migrant workers and women in the

military were included.

Invitations to the June meeting of the Advisory Council were accepted by 17 members of the House of Representatives, as well as representatives of the White House Office of Drug Abuse Policy, the Office of the Secretary of Health, Education and Welfare, the Veterans Administration, National Institute on Drug Abuse, the U.S. Commission on Civil Rights and representatives of the House Judiciary Committee, the Senate Subcommittee on the Constitution, the Select Committee on Narcotics Abuse and Control, among others. The group was addressed by Representative Peter Rodino and by other distinguished speakers who focused on the needs of women with substance abuse problems and the necessity of providing assistance to these women.

Delegated Responsibilities

The Regional Coordinators were given the following responsibilities:

- Identifying Captains for each state;
- Scheduling two regional meetings, the first an orientation and strategy session for designing processes for gathering and analyzing information, and the second a reporting-out session to review

the progress of the state reports and develop a timetable for the Coordinator to deliver the reports to NRCA;

- o Preparing vouchers for expenses and submitting them to NRCA for approval and payment;
- o Assisting the Captains in developing their state networks;
- o Analyzing and preparing the regional report from information supplied by each state;
- o Presenting the regional report to participants at the D.C. Symposium and assisting in the development of a corrective-action conference agenda.

NRCA assisted the process through the following measures:

- o Developing a factbook including information on:
  - a. Administration--for the preparation of expense vouchers, budget breakdown and related materials;
  - b. Information gathered from various sources on organizational strategies and philosophies;
  - c. Resources available through Advisory Council members;
  - d. Additional resources that might prove useful, such as "The Roster of Women State Legislators, 1977" from the National Women's Education Fund;
  - e. Suggestions for getting attention through the media;
  - f. Survey instruments, data, and related materials of potential usefulness to members;
  - g. A review of legislative action pending or passed in the Congress and by other legislatures;

h. Lists of agencies, organizations and individuals who might become coalition members;

i. Reports on regional meetings and related events.

- Processing travel arrangements and per diem for participants at the regional meetings;
- Attending each regional meeting to present an overview of the project, report on progress within other regions, and to assist in developing regional and state plans of action;
- Suggesting information-gathering instruments and techniques;
- Providing formats for the state and regional reports to produce a consistent response;
- Providing Coordinators and Captains with duplication, media, and mailing assistance to supplement regional budgets.

The Process

The professional affiliations of the Coordinators indicate the broad representation emphasized in the Alliance effort:

Region I--private sector (consultant in social services)

Region II--Single State Agency (administrator)

Region III--State-funded drug program (trainer and program evaluator)

Region IV--University (professor)

Region V--State Mental Health Coordinator

At the start of the project, NIDA sent letters to the Single State Authorities (SSAs) describing the intent of the Alliance and requesting cooperation. Four of the five Coordinators followed up the contact with the SSAs within their region and solicited their cooperation and recommendations

for State Captains. Almost all the State Captains contacted their SSAs, State Alcohol Authorities (SAAs) and Mental Health offices. Several also communicated with State Planning Agencies.

NRCA contacted the SSAs that did not respond to requests for cooperation and discovered that, in the majority of instances, the letters to the SSAs from NIDA, the Coordinators, and/or Captains had not reached the administrator. This subsequent personal contact generally led to support and cooperation.

The following examples of the organizing strategies used by the Regional Coordinators shows the diversity of their techniques:

Region I. A group within the region had remained active since the formation of the coalition at the 1975 conference. Their participation in the Alliance provided a mechanism for strengthening their network to include states which had previously been unable to work with the existing coalition because of travel constraints or a lack of state organization.

Captains were chosen from the existing coalition members or, in states where participation had been minimal, through recommendations by state agencies.

The Regional Coordinator sent letters to all SSAs, SAAs and Mental Health offices in the region inviting participation.

An orientation/strategy meeting was held for the Captains and the Coordinator described the scope of the project.

Six areas of concern were selected for information-gathering: administration; education for prevention; legislation; research; training; and treatment. Because of the differences within the states, it was decided that each state would develop its own system for collecting the necessary information. Massachusetts and Rhode Island subsequently organized state-wide meetings, while other states collected their information through management information systems, informal surveys, or by scheduling community meetings.

Captains presented their reports of activities and findings at a second regional meeting.

Region III. The Coordinator invited SSAs, SAAs and Mental Health Administrators to assist in selecting the State Captains. State task forces formed after the 1975 conference assisted in several states.

At the orientation/strategy meeting, the roles of the Captains and the anticipated results were described. A communications network was developed and maintained between the states through a "buddy" system and weekly newsletters from the Coordinator.

Captains developed their reports from information obtained from the SSAs, mental health agencies, criminal justice system, social service organizations, women's groups and local task forces. Questionnaires were designed and circulated and community meetings held to enhance the information gathering process.

A second meeting was held to discuss progress within each state, to provide assistance with any problems and to develop a format for the state reports.

All materials were sent to the Coordinator for submission to NRCA.

States' Efforts

Multidisciplinary representation was a factor in the selection of State Captains. Of the 55 Captains who participated (Massachusetts, New Jersey, and New York each had Co-captains, one for drugs and one for alcohol), 52 percent were affiliated with state agencies and 48 percent were from private sector organizations or state-funded programs.

Because of the disparity of organizational development and information systems within the states, the information gathering techniques were varied, as illustrated by the following examples of state strategies.

Rhode Island. Prior to its participation, the state had no coalition, nor had any needs assessment been conducted. The Captain organized the state by creating committees and assigning responsibility for each of the issue areas agreed to at the regional meeting.

Participants were drawn from public and private sector agencies and organizations, including the Governor's Office, the Department of Corrections, the Department of Elderly Affairs, the University of Rhode Island, and state or privately-funded alcohol and drug programs.

The committee structure developed for participation in the Alliance formed the basis for an on-going coalition network within the state. The reports developed for the Alliance were accepted by the state's Division of Substance Abuse and will be used to develop policy and for incorporation into the 1978-79 Alcohol and Drug Abuse State Plans.

North Carolina. An existing Task Force on Women and Alcohol agreed to participate in the Alliance. The Captain enlarged the membership to include equal numbers of representatives from the drug abuse and mental health fields, who joined with the original members to prepare the state report.

Now known as the Women, Alcohol and Drug Abuse Task Force, the group has expanded its activities and has plans for a women's awareness week and the formation of a Task Force Advisory Council, including community representatives as well as drug and alcohol professionals. The Task Force has received support from the Secretary of Human Resources and the Deputy Director for the Division of Alcohol and Drug Abuse.

Massachusetts. The State Co-captains represented the Divisions of Drug Rehabilitation and Alcoholism, both under the Department of Mental Health. Both used the existing organizational structure within the state. For example, the state is divided into seven regions under the Division of Drug Rehabilitation. The Co-captain scheduled meetings in

each region to conduct interviews and administer questionnaires to the drug coordinators responsible for monitoring programs and to the drug program staff. Additionally, questionnaires were given to the Director of the State Division and his staff. Information was also obtained through the state management information system, CODAP, and research studies. This approach provided an in-depth perspective on staffing patterns, client characteristics and needs, and gaps as well as strengths within the organizational structure.

The Co-captain representing the Division of Alcoholism gathered information from the central and regional offices of the SSA Division of Alcoholism, from program directors and staff, and from interest and advocacy groups. This provided a broad view of the issues and also permitted comparison of special treatment needs as perceived at the various levels.

Media Involvement

Throughout the project, major efforts were made to gain attention and publicity through the use of the media. Initially, NRCA developed publicity for trade and professional journals, and for Advisory Council newsletters. In response to requests for assistance in getting local media attention, NRCA also developed materials describing techniques for gaining local media coverage, including sample TV and radio spots.

In addition, NRCA sent press releases to print outlets within the states describing the project and announcing the appointment of a State Captain or Regional Coordinator for the national effort.

The media activity produced a vast amount of public response to the Alliance efforts, as indicated in an accompanying list.

To accommodate requests for further assistance, the D.C. Symposium included a panel on the media--where panelists--Bob Levey of the Potomac Journal/Washington Post, Harvey Hebaker of the Washington Star, Helen Dudman of WETA-TV, and Carol Randolph of WTOP-TV--described techniques that can be used to increase media response.

Public Forums

The Alliance received numerous requests to participate in meetings and forums. In addition to queries for information on the project and its process from other countries, and from programs, countless individuals requested information and assistance--both about the general problem and for personal referral.

In some instances where NRCA was invited to attend gatherings--as examples the CSTAA/NASDAPC meeting, the Latin Women's Conference, and Selfhood, a seminar in South Carolina--brochures about the project were provided for distribution and an Alliance member was asked to represent the project.

Other examples of public forums where the Alliance was represented include:

--The National Drug Abuse Conference where NRCA established a hospitality and meeting space, distributed press/information kits, conducted press interviews and made a presentation at the Women's Forum workshop which resulted in 75 new Alliance members.

--Participation in the Women and Health Roundtable, a project of the Federations of Organizations of Professional Women sponsored by the Rockefeller Foundation, where NRCA made a presentation on the Alliance effort. Roundtable participants represent national organizations and agencies concerned with legislation relating to women and health.

--The presentation on drugs and alcohol for the President's Commission on Mental Health, Women's Panel, was prepared by NRCA and reflects relevant data gathered by Alliance members. The 15-member Women's Panel, drawn from various states, disciplines and special interests, has prepared a submission of policy recommendations to the Commission.

--Because of the perceived significance of the Alliance, a discussion of treatment programs for women offenders was scheduled for the first time at the yearly meeting of the State Planning Agency representatives and directors of Treatment Alternatives to Street Crimes (TASC) programs. NRCA was later informed of TASC's intention to develop a pilot demonstration project in a woman's prison.

Selected State Activities

The enthusiasm and activities created by the Alliance project led to a number of new initiatives in behalf of women at the state level. Examples of these were:

Wyoming. The Captain presented a resolution on problems of women and substance abuse to the state International Women's Year conference. The resolution was adopted and the Captain was elected as a delegate to the national IWY conference in Houston.

Pennsylvania/Minnesota. A working relationship established through participation in the Region II coalition led to a collaborative grant proposal for a project to study the relationship between drugs, alcohol and spouse abuse.

Montana. The state authorized $25,000 to establish an advisory task force on women and substance abuse.

Maryland/Ohio/Hawaii. Resolutions concerning the problems of women and substance abuse were submitted by the Captains to their state IWY conferences. The resolutions were adopted.

West Virginia. The first women's substance abuse task force was formed by the State Captain.

Nebraska. The Captain developed a new grant proposal regarding women and treatment.

Utah. A course on drug and alcohol use is being developed by the captain for the University of Utah.

Illinois. The Captain established a closer working relationship between the Department of Dangerous Drugs and the Child Welfare Bureau in order to develop new techniques and facilities which would better meet the needs of addicted parents and their children.

Such activities are only a beginning. Certainly, there is reason to assume that much more is taking place on the state level. With the new awarenesses, the new contacts, the new channels of communication that have evolved as a result of this project, the dynamics within each participating state have changed considerably. As a result, states are not only in a better position to provide Federal agencies with planning advice on the needs of women but are also better able to recognize and resolve many of their own problems, drawing on a greater variety of resources than was previously possible.

INFORMATION ANALYSIS: A STRIKING UNANIMITY OF FINDINGS

Drugs, Alcohol and Women's Health: An Alliance of Regional Coalitions was formed to gather information about these specific women's health problems and needs, to discover what is currently being done, and to suggest what remains to be done.

In an eight-month period, this effort yielded five regional reports and 49 reports from the states and the District of Columbia. Two meetings held in Washington, D.C. and 10 regional meetings were held to discuss needs and assess findings. The information in this summary report has been gleaned both from the written documents and from the meetings.

Although the information was gathered in different ways, and demographic differences from states were marked, there is a striking unanimity in both the perception of needs and suggestions for resolution.

Certain themes run throughout the reports--obvious enthusiasm among those who found new resources and new contacts within their states and saw the possibilities of finally getting something done to help women, frustration at not being able to get certain information, and time constraints, felt particularly by those who were trying to meet both a job obligation and the requests of the Alliance.

Some comments from the reports reflect the rewards, hopes, and frustrations:

"Persons involved in the field, especially women, were excited and eager to be helpful...."

"We participated because we are still committed to the hope that maybe this time someone will listen."

"This report only scratches the surface of the nature and scope of the problems the Coalition is trying to confront...."

"One of the frustrations was the 'snow-balling effect' of getting more contacts and hearing of more and more programs, then wanting to contact them but just not having enough time...."

"I have benefited in being pushed to consider the issues which are being raised...there are other people who have a great many ideas and proposals but need a forum for expressing these and the encouragement to think about some new approaches...."

Throughout the reports, certain problems with definition were apparent. The term "women's health," for instance, seemed to be so all-encompassing that the reports tended to focus primarily on substance abuse. The time constraints of this project may have inhibited the consideration of the larger implications. Only occasionally were there mentions of such "women's health" concerns as rape, abortion or wife battering.

Also, the distinctions between alcoholism and drug abuse blurred--except in those few states that addressed the two issues separately. The common problem became "substance

abuse," and common needs were identified, without regard to either specific substance. In discussions, Alliance members expressed concern about growing degrees of "stigma" between drug addicts and alcoholics. The distinction is a reflection of the rationale that alcoholism is a "disease" while drug abuse is "self-imposed addiction." In the minds of some participants, this threatened to create different classes of substance abusers--those who were to blame for their problems and those who were not.

Some obvious omissions from the reports are also worth noting.

The subject of smoking, for example, was not mentioned, despite the fact that women are rapidly approaching parity with men in the incidence of lung cancer, emphysema, and the evidence of increased circulatory disorders among women who smoke and also take birth control pills.

Nor was obesity, the consequence of another type of "substance abuse" and one with serious health implications, mentioned, even though obesity is common among women.

Also notable for its absence in the written reports was mention of marihuana or the possible health implications its frequent use may have for women. In discussions, though, participants were concerned about the overall impact of lessening sanctions for marihuana use when treatment programs are trying so hard to be "drug free" and prevention efforts striving to promote "drug free" alternatives.

Common Problems

While the information in the reports may not be conclusive, nor was it gathered in identical ways, distinct patterns did emerge, providing a diverse grassroots perception of problems and needs. Many similar observations and suggestions were found in nearly every report. The following summaries are discussed in greater detail in succeeding sections of this report:

--The scope of the substance abuse problem among women has never been adequately documented. Drug and alcohol abuse appear to cut across all economic, social, racial, and cultural boundaries, but many--perhaps the majority--of women substance abusers are "hidden." They do not become "statistics" until confronted by a crisis that forces them to seek help.

--The stigma attached to the use of drugs or alcohol by women makes it difficult for them to admit their problem, seek help, be rehabilitated and then accepted by society.

--The use and/or abuse of more than one substance is common among women, yet there is little help available for those with polydrug or cross-addiction problems. In many parts of the country, a woman in a drug treatment program will not be accepted by an alcoholism program, even though the problems co-exist.

--The common denominators of loneliness and isolation, lack of self-confidence, and limited survival skills add to the difficulty in identifying women with substance abuse

problems, many of whom use these substances to cope and do not recognize that their coping technique is, in itself, a problem.

--Women who abuse substances often have other serious health problems, yet these are rarely identified or treated.

--Women's substance abuse is detrimental to their children, often leading to deformities and infant addiction, child abuse, and the distinct possibility that the children themselves will also engage in self-destructive behaviors.

--There appear to be few differences between the needs of the woman drug addict and the woman alcoholic, yet the needs are separated bureaucratically as well as by a therapeutic rationale that establishes alcoholism as a "disease" and drug problems as a self-imposed "habit."

--An unknown number of women are dependent on legally obtained drugs--primarily tranquilizers, sedatives, and amphetamines--prescribed by physicians in response to such generalized complaints as depression, anxiety, insomnia or nervous tension.

--Many women will not seek treatment because they are fearful of losing their children if they admit to an alcohol or drug problem. In many states, that will happen.

--Women who are not substance abusers themselves are frequently the victim of a man's substance abuse, a finding widely confirmed by counseling "hotlines" and emergency crisis shelters.

--Women's treatment needs extend beyond detoxification or drying-out. Yet funds are rarely available for medical, counseling, and social services, or for child care, all of which are vital to treatment for women.

--Unemployment and underemployment are common among women substance abusers who typically lack vocational and job or job-seeking skills.

--Rural women who turn to substance use to escape their isolation are especially difficult to reach because so few alternatives exist for them, services are not convenient, and transportation is difficult.

--Many programs and services, each with the potential for assisting women, operate in isolation, are poorly coordinated, rarely aware of other resources, and sometimes work at cross-purposes.

--Women are underrepresented in statewide administrative and planning positions where they might have an impact on the provision of treatment and services for women.

--Although most states recognize the need to provide treatment services for women, few have provided the funds or developed specific programs for the purpose.

--Physicians, social workers, counselors--the whole range of professional and service personnel who have contact with women--are rarely able to identify substance abuse problems or to provide appropriate information, referral, and treatment.

SIMILAR SOLUTIONS

Many of the reports offered similar solutions for these problems. In fact, the first 12 suggestions were found in every report that proposed concurring remedies, while the last three were mentioned in at least 75 percent of the reports. They were:

--A single, coordinated and comprehensive data system is needed at the national level to provide the necessary information for future health and service planning.

--The resources and program efforts of all appropriate state agencies should be coordinated to provide non-threatening, comprehensive health care services for women.

--Each state should increase both the numbers and the types of facilities available to help women.

--Such ancillary services as child care, vocational training, education, and legal assistance should be assured for women who seek treatment.

--All health and social service professionals should be trained to identify and to assist with the specific problems that lead women to abuse drugs and alcohol.

--Each state should survey the different needs of men and women in their population to serve as a basis for alcohol and drug treatment programming.

--New techniques are needed to reach and identify the unmeasured and unidentified populations at risk.

--Diverse and effective public awareness programs, responsive to specific local problems and needs, are needed in all communities.

--Each state should have a full-time staff person responsible for women's issues.

--Women should have greater access to administrative positions, particularly those involving planning and program development for women's health services.

--Task forces should be formed in each state--including members from diverse ethnic, cultural, socio-economic and age groups--to develop statewide and community linkages.

--All staff members in programs that serve women should receive training on the special needs and problems of women.

--Each state should maintain communication with other states to share program information.

--All states should review the appropriation and allocation of funds to assure equalization of services.

--Statewide alcohol and drug agencies should work with the criminal justice system to provide training and program development for women offenders with drug abuse and/or alcohol problems.

Participants also specified the need to continue the Alliance so that the enthusiasm, optimism and cooperation generated by the eight-month effort will not die, but can be invested in the further development of a more viable and creative approach to providing health care for women.

SOME PERSISTENT COMMON DENOMINATORS

In much of Alaska, winters are long and bleak. Life is frequently hard, especially for women. Many are newcomers who have followed husband and job, but have no extended family or friends, no place to turn in adversity. Jobs are hard to find, wife battering is common, and the divorce rate is 52 percent higher than the national rate.

It should not be surprising that the use of alcohol and drugs is high, or that the "at risk" group for abuse includes all but the very young and the very old.

Nor should it be surprising that studies show drug users and alcoholics are bored and lonely people, new to the area, having trouble adapting to the severe climate or to the drastic cultural changes.

Perhaps what is surprising is that under these circumstances some women have found other techniques for coping with the harsh life.

While the problems of women are intensified by life in Alaska, the problems are not peculiar to Alaska. As participants discussed and described these problems, it was clear that there is no homogeneity among women who use drugs and alcohol. They are young and old, rich and poor. They live in cities, in suburbs, in rural areas.

It was also clear that there are common denominators, certain patterns or "risk" factors that make some women more vulnerable to substance abuse than others. Perhaps the

most basic of these are isolation and loneliness, but they also include feelings of worthlessness, lack of self-confidence, feelings of frustration and inferiority. Many women who become abusers do not seem to be able to identify or solve their own problems. Some lack basic skills needed for survival; others are overburdened by the demands of survival. For some, life is too easy; for others, too hard.

These women are not necessarily weak, dependent, deviant, promiscuous, or unfit. Some are poorly educated. Many have no jobs and no vocational skills. Some are trapped in crowded ghettos, some in affluent suburban homes, some in isolated rural farmhouses. They feel hopeless and helpless. They see no way to escape.

Many of the stresses suffered by women are not shared by men. These are stresses related to traditional views that women's role is to serve, that they are dependent and weak. Such views place many in a "Catch 22" situation, torn between their own dreams and ambitions and the expectations of a still-traditional society.

Life Situations and Patterns

Throughout the reports, it was evident that certain crises can turn use into abuse and that women need help particularly at such times as early marriage, the birth of the first child, an unwanted pregnancy, separation or divorce, widowhood, rape, menopause, or major surgery, for example mastectomy or hysterectomy.

It was also evident that certain life patterns and life situations are closely related to substance use and consequent abuse.

The plight of rural women for instance was succinctly described in the report from Nevada, which shows one of the highest alcoholism rates in the country. *"Traditionally, it is the head of the household, usually the male who has the job. The rural women have assumed predominant role of homemaker. In urban settings she may be involved in numerous other activities as well as local women's movements, consciousness-raising groups, cultural endeavors, professional work status and so on. In a rural community, few of these opportunities are available to the woman who wishes to expand the realm of her existence and there is little in terms of cultural activities. There is little in terms of continued education, because most rural areas have no colleges or universities. There is insufficient opportunity for her to have professional status in employment."* Further, the report concluded, *"the picture is frequently dismal, and, for many women living in the rural West, alcohol is a powerful seducer to help her compensate for the dullness of her life."*

Implicit in this description is the fact that many rural women are economically dependent on men, and often they are totally isolated from family or friends.

A similar description could be provided for the urban ghetto dweller, whose isolation, lack of opportunity and dismal

existence have many parallel stresses which are frequently compounded by cultural barriers and an inability to speak English.

Other life situations often associated with substance use and abuse among women were described in the reports:

--Even though many women are satisfied with their roles as mother and homemaker, many are not, particularly those who have abandoned their own ambitions and goals to assume their "proper role" in life. They are frustrated, but they also feel guilty because they want something more of life. Those who do find satisfaction in traditional roles often discover such satisfaction is transitory. Children grow up and mother is no longer "needed." Then they are confronted with the widely publicized "empty nest syndrome," when they realize they have nothing to do with their lives. Too, there may be a divorce or death and they discover--late in life--that they have few resources, few skills, and no real system of support.

--No matter how competent the working woman is, she frequently feels she must be twice as good as a man to prove her competency, that she can never afford to slip up or make a mistake, that she must demonstrate she can "think like a man" and even, when the occasion demands, drink like a man. Socially she faces pressures. If she is single, she may be seen as a threat to those who are married because of her professional competency, and she may be viewed as loose or

promiscuous. If she is married, she also has the pressures of maintaining a home, of being a wife and mother--traditionally without much assistance from the man. She really holds two jobs, the one in the home and the one outside the home, with dual responsibilities and dual pressures.

--The single mother who must support her children has that added economic burden. Census figures show that some nine million families are headed by women, many of whom work long hours at low-paying jobs, maintain homes for their children, are constantly worried about money--rarely able to afford care for their own health problems or the education/training that might lead to a better paying job--and are always over-tired and overburdened. Many of them are minority groups members; many do not speak English. Many live in neighborhoods where they fear for their own safety and for that of their children. They have no way out, no escape except through alcohol and drugs.

--Women who are divorced share similar problems. Often they are impoverished, fearful that some illness or crisis will cut into their meager incomes. Many have no job skills but do have the responsibility of raising their children and maintaining a home. They face the insecurities of divorce, uncertainties about themselves and their future. They are alone, yet afraid of being lonely. Often they are shunned by former friends. Often they are afraid of developing new relationships.

--Moving makes many women the casualties of their husband's success. Moves are usually made to benefit husbands but are disruptive and traumatic for wives who lack the built-in social structure afforded by the job and must start again from the bottom, finding new friends, a new place in their community, a new identity. The problem is particularly acute for military, foreign service and corporate wives who are forced to accept moving as a way of life. The extent of this was demonstrated by a study in the city of Alexandria, Va., which showed that 52 percent of household heads were newcomers to the area. The consequences of frequent moves appear to be chronic depression, a lack of hope or desire--and, not uncommonly, addiction.

--The crises of the teenage years and the formidable peer pressures to drink or experiment with drugs make substance use tempting, particularly for those who have trouble "coping" and those who want to be "popular." Yet the problems of the teen years are not confined to peer pressures and coping. Growing numbers of teenage girls are runaways, victims of child abuse or fleeing from unloving homes where one or both parents abuse drugs and/or alcohol. They have no place to turn, no place to go but the streets where they, too, become involved with substance abuse as a way of life.

--Pregnancy is a vulnerable period, particularly when pregnancy is unplanned or unwanted. Each year nearly one million teenagers become pregnant, 30,000 of them under 15 years of age. Statistics show their health problems and the

risk of fetal damage is twice as great as with older women, and that the rates of drug and alcohol use by youthful females is increasing in far greater proportions than that of young men.

Pregnant women who abuse drugs or alcohol endanger their own health and the well-being of the fetus. Commonly their babies are born addicted. Typically they are not adequately nourished, and often have venereal disease. Heavy use of alcohol during pregnancy can cause deformities. Pregnant addicts are often reluctant to seek care because many states view substance abuse as prima facie evidence of being "unfit" as a mother, and they fear that the child will be taken from them.

--Elderly women often live on fixed incomes that restrict their activities. They have too much free time, they are often bored, often lonely. Many have physical complaints and are accustomed to taking medication--typically many different kinds of medication--to solve the problem or ease the pain. Chronically depressed because they feel they are no longer good for anything and that they live in a society that rejects them, alcohol and drugs are an appealing alternative. Sometimes they are even encouraged to drink or deliberately given drugs so they will be "easier to handle," less of a problem to those who "care" for them.

--Women in prison frequently have well-entrenched substance abuse problems that have never been identified or

treated. Often this occurs because the criminal justice system is initially more lenient with women. For example, an inebriated woman driver may be booked on lesser charges and escorted home instead of being charged with drunk driving. Such actions ignore the behavior until deviant patterns are firmly ingrained and the woman is finally imprisoned, with a long arrest record, no resources and little hope for rehabilitation. Medical care in prisons is sporadic, and sometimes non-existent, although gynecological problems, nervous tension and anxiety, headaches, pain, chronic illnesses like diabetes and hypertension are frequently reported. A study of women's correctional programs conducted by the National Institute on Law Enforcement and Criminal Justice showed the widespread use of tranquilizers and mood elevators--ranging from zero in Minnesota to 98 percent in San Francisco's jails--probably as a means of controlling the inmates, and concluded "*one can only speculate on the impact of such long term medication upon physical and mental functioning of inmates and the impact of psychological dependence on such drugs among inmates released from institutions and expected to assume a responsible, self-directed role in society.*"

The reports identified a number of other factors relating to women and substance abuse:

- Many use and/or abuse more than one drug--80 percent of women alcoholics in one study reported they used other drugs as frequently as alcohol--making polydrug abuse and cross-addiction a significant problem among women.

- Middle-age, middle-class women are susceptible to prescription drug abuse, with medications

provided to help them "cope." Eighty percent of prescriptions for mood altering substances are from internists, general practitioners and obstetrician/gynecologists who have no training in psychopharmacology, only 6 to 9 percent from psychiatrists who do.

- There is little data on alcoholism and working women since the symptoms--irritability, somatic complaints, fatigue--are vague and nonspecific and women who tend to have low-paying positions are easily replaced if they fail to perform.

The Extent of Abuse

How extensive is substance use among women? The reports suggest repeatedly that those who have become "statistics," because they have been forced to seek treatment in a crisis situation are "only the tip of the iceberg," that substantial numbers are using drugs and/or alcohol, have not yet had visible trouble, and that large numbers are in trouble but remain unidentified. Although no overall figures and no precise measurement of the problem exists, a number of separate indices--statistics, observations, local surveys--suggest the magnitude of the problem. For example:

- Statistics show that 60 percent of psychotropic drugs, 71 percent of antidepressants, and 80 percent of amphetamines are prescribed for women.
- One in five divorces is related to alcohol abuse.
- Studies of drinking among teenagers show the greatest percentage increase is among girls.
- The number of deaths from cirrhosis is increasing among women.
- According to current estimates, half of the presumed 10 million Americans who are alcoholics are women.

- An additional 40 million women are considered "other victims"--wives, children, mothers--of alcohol abuse.

- Emergency room surveys show that some 90 percent of drug overdose incidences involve women who have abused licit substances.

- A survey in South Dakota showed that housewives were heavily involved in barbiturate use, and regular use of minor tranquilizers, amphetamine diet pills and analgesics.

- In Virginia, half of all drug deaths and the majority of drug overdose emergency cases were among white women, who represented only 17 percent of those in treatment. Middle age white women were overrepresented in drug deaths and overdose emergencies, especially in cases involving barbiturates and tranquilizers, and almost half of accidental drug deaths involved white women over the age of 61.

- In Utah, studies showed that 69 percent of unemployed women who are members of the Church of Latter Day Saints over the age of 34 used minor tranquilizers, and at the age of 45 to 50 these women are a major risk population for alcohol abuse.

- During 1975, 57 percent of the hospital overdose cases in Rhode Island were female and 86 percent of "people-in-trouble" drug related calls were from women.

- Up to 60 percent of those who seek psychological assistance for depression have alcohol problems; one in three of them is a woman.

As the problems confronting women were identified throughout the Alliance reports, the pieces began to fall together, yielding a clearer--but still far from complete--picture of the issues involved. What becomes most apparent is that the issues raised do not just focus on women who abuse drugs and alcohol, but affect the health of society as a whole. With understanding and effort, these can be remedied by

providing women with more options and with alternative methods for coping with problems and frustrations.

"Grassroots" suggestions for new policies, new approaches, and new collaborative efforts that would address these issues and ease problems for women, particularly those who are "at risk" or already substance abusers, are outlined in succeeding sections of this report.

HUGE GAPS IN KNOWLEDGE

Much remains to be learned about women's health and about the particular problems that cause some women to turn to drugs and alcohol.

The fact that there are huge gaps in knowledge about the subject is apparent throughout the reports and in discussions with Alliance members.

Some of the missing knowledge is very general. What, for instance, does good health mean for women? Physically? Psychologically?

Some is far more basic. How many women are affected? What factors make some women more vulnerable than others?

Sometimes the gaps exist because the knowledge is not available, sometimes because, even when available, the information has not reached those who need it.

One State report summarized the problem succinctly:

"There is research being done in the State of Connecticut on women and alcohol and drug abuse. This research is carried out by programs providing services as well as in the various colleges and universities around the state. The scope of this research varies from programmatic developments to sociological studies, to hard scientific research. We feel that the problem in this is the lack of coordination of these efforts and the lack of sharing of information being developed by these projects. We recognize that the main problem encountered here is due to the many and varied funding sources that these projects are working under."

Throughout the reports, there seemed to be a lack of awareness of research that was being done. Many were not even aware of studies or projects being conducted by other groups within their own state. Several complained of participating in projects, then being unable to learn the results. Others complained it was virtually impossible to get information from Federal agencies, and that these agencies did not seem to be aware of relevant studies and research being pursued by other agencies involved.

Many were actually aware of the information deficiencies because such deficiencies hamper development of effective programs for women. The research and information needs seemed to fall into four categories: basic research; program research and evaluation; epidemiological data; and sharing of information.

Possible Research Topics

A number of questions raised throughout the reports may provide valid topics for future research. In addition to defining what "good health" means for women and determining how many women are affected by substance abuse problems, these included:

- What specific problems place certain groups "at risk" for substance abuse? Such groups include teenagers, pregnant women, minority group members, housewives, working women, the unemployed, single mothers, divorced or separated women.
- What warning signs and symptoms might lead to early identification and possible intervention?

- What impact does family violence, moving, divorce, or unemployment have on the development of substance abuse?

- What are the strengths of women who have chosen to "cope" by using drugs and/or alcohol?

- Is there a relationship between the "empty nest syndrome" and substance abuse? What alternatives exist?

- What effect does a husband's drug usage have on that of his wife?

- To what extent and in what ways do advertising and marketing techniques and physicians' prescribing patterns influence abuse of drugs and alcohol by women.

- What is the relationship between hormonal changes and the use and effects of drugs and alcohol at different stages of a woman's life, especially at puberty, during pregnancy and during menopause?

- Do physicians diagnose "depression" and "anxiety" differently for men and women?

- What is the relationship of various stages of the menstrual cycle to drug and alcohol metabolism?

- What are the physiological and psychological effects of substance abuse on teenage girls?

- Do different cultural patterns and beliefs influence a woman's use of drugs and/or alcohol?

Certain specific issues were mentioned repeatedly. One of the most persistent was the fact that women of childbearing age are routinely excluded from research projects involving drugs. Until recently, for instance, women were not included in studies of the use of marihuana as an antiemetic for patients undergoing cancer chemotherapy, and women are still excluded from programs to evaluate the effectiveness of LAAM, a longer acting narcotic maintenance agent similar to methadone.

Another critical need is for further studies on the long-term effects of drug and alcohol use by pregnant women on the fetus. While the effects of alcohol, heroin and methadone have been documented, little work has been done on marihuana or other substances.

Yet another need is for studies of the use and abuse of such prescription drugs as tranquilizers, sedatives, mood-elevators and the hazards of their combined use with other medications and with alcohol.

The need for research on treatment and for the evaluation of treatment was also emphasized, and a number of major, unresolved treatment issues were identified. Many are discussed more fully in the section dealing with treatment. These included:

- The effectiveness and appropriate use of such techniques as assertiveness training, confrontation, self-help groups, psychotherapy, behavior and certain drug therapies;
- The effectiveness of totally separate treatment programs for women versus sexually integrated but specialized treatment programs;
- The validity of the idea that female staff members serve as valuable role models and facilitate the rehabilitation process;
- The relationship between the attitudes of service-providers and program administrators towards women with substance abuse problems and the success of treatment;
- The usefulness of such alternative approaches as paraprofessional and peer group techniques in place of more conventional medical treatment models.

Need for Information

The need for precise information about the extent of substance abuse among women, with specific efforts to identify those who are "hidden" abusers and those in isolated rural areas is obvious. Without such data--and particularly data that identifies high risk groups and demographic differences--the design of effective approaches to prevention and treatment is virtually impossible.

The state reports did show widespread access to the data on drug abuse treatment programs and alcoholism programs gathered by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alocholism.

Yet, for program planning purposes, this information was felt to be insufficient because it included only women who enter Federally-funded treatment programs. It does not reflect the untold numbers of women--particularly those who abuse prescription drugs, are hidden alcoholics, or have cross-addiction problems--who do not become "statistics" because they have not sought help from Federally-funded programs. It has been assumed that many either have not sought treatment or have gone to private physicians or private programs. This assumption should be examined.

Current data also fail to document the extent of substance abuse in such groups as welfare recipients, ethnic minorities, women in prisons, women in mental hospitals, pregnant women or teenagers--information that should be available within each state.

The data-gathering efforts of Alliance participants enhanced the frustrations that many already felt about being unable to obtain information that is theoretically available.

A specific complaint concerned the difficulty in getting information from the government. One participant reported querying clearinghouses numerous times to no avail. There was concern expressed that many studies, when completed, only gather dust on shelves in Washington instead of being disseminated.

As they collected information for the state reports, many learned about the extent of the information available within their own states for the first time, and of the potential information resources. And, at the same time, they were confronted by the paucity of information that they expected to find. Many were hindered by a lack of coordination and cooperation among various state agencies and groups which should have been able to provide information. For instance the criminal justice system in many states did not have information about the extent of substance among women in prison.

Similar problems were identified at the Federal level, since many of the agencies with studies and programs affecting women do not communicate findings or share efforts. A specific frustration was the inability to learn what kind of research was being done or where.

Many reports specified the need for better and more coordinated data-gathering and dissemination efforts at the

state, regional and national levels. A regional clearinghouse system would assure the availability and widespread dissemination of current research findings. At the Federal level, the need for a single system to collect information on health, consolidating and elaborating current data-gathering efforts was cited. Such a system would be more efficient than the current fragmentary and sometimes overlapping methods and would provide a substantial and consistent basis for future health planning.

OPTIONS TO REINFORCE THE VALUE OF POSITIVE BEHAVIOR

To establish a common basis for discussion, members were provided a working definition of "prevention":

"Prevention involves those tasks, ideas and methods designed to promote constructive life-options which will reinforce the value of positive behavior and thereby lessen the probability that an individual will develop destructive patterns."

The challenge posed by prevention was widely discussed by Alliance participants and received high priority in their reports. Even with a working definition, there seemed to be ambiguity about what effective prevention really involves.

It was agreed that prevention should focus on positive health, not merely on discouraging substance abuse, and that fear and scare tactics alone should be avoided.

But distinctions between such concepts as prevention and early identification/intervention, between prevention and treatment, and between prevention and education/training were blurred, indicating, perhaps, the close interrelationships between these concepts. In fact, public and professional training and education efforts were seen as essential components of all prevention efforts.

The reports seemed to agree that prevention efforts targeted at women's substance abuse have, thus far, been sparse or ineffective, emphasizing the need for new approaches at both the national and community levels.

Federal/State/Community Roles

The national role involves leadership, cooperation and coordination of efforts among the various governmental agencies whose programs affect women in order to alleviate and eliminate some of the problems and stresses known to lead to alcohol and drug abuse.

For instance, it is well-established that overcrowded living conditions create stress. If this is so, then Federal housing projects should be designed not only to alleviate overcrowding but to take into account the emotional needs of residents.

Since it is known that school drop-outs frequently have drug and alcohol problems, alternative education programs should be developed which anticipate their vulnerability, particularly in the junior high years, and try to make education a more positive and dynamic alternative. The current middle-school curricula has not been redesigned for 40 years in many public school systems.

The national role also involves providing funds for research essential to the development of effective prevention, for documenting the extent of substance abuse problems, and for identifying the factors that place some women more "at risk" than others.

Since alcoholism is a leading cause of death, many felt that the Federal government has a responsibility to require that all alcoholic beverages carry labels with a warning

similar to that found on cigarette packages, specifically mentioning the potential damage to an unborn child when a pregnant woman abuses alcohol.

Labeling for potentially addictive or dangerous prescription drugs and over-the-counter medications was also advised, since many women inadvertently misuse them or use them dangerously in combination with alcohol or other substances.

Medical journal advertising and promotions for "pop" wines and similar sweet alcoholic beverages also caused concern. Typically, advertisements for sedatives, tranquilizers and mood elevators directed at physicians portray women as anxious, depressed, in need of a medical "crutch" to deal with their problems, and thus reinforce the tendencies of physicians to prescribe such drugs for those problems. And advertisements for "pop" alcoholic beverages are often aimed at young people who might not normally drink and may not be adequately aware that these alcohol-containing beverages are potentially harmful.

Local programs should be geared to meet specific problems within a community and should involve wide community representation, the reports suggested. Some states advocated the formation of citizens' task forces or advisory groups, involving public and private organizations, business, industry, unions, women's clubs, churches, senior citizens and youth

groups, in order to stimulate effective alternatives to substance abuse for women.

Target Audiences

The reports concurred that prevention efforts must be aimed at many audiences--at the general public, at women in general, at women who are "at risk," and at those in the medical, legal, social service and treatment systems who come in contact with women.

The need to erase the "stigma" associated with substance abuse by women was repeatedly stressed. This presents one of the most pervasive problems encountered by women who use alcohol and/or drugs and is a serious barrier to their successful treatment and rehabilitation.

While society tends to accept the fact of alcoholism and drug abuse in men, women's drug problems are neither accepted nor tolerated. A woman is labeled, instead, as unfit, deviant, weak, "fallen," often by herself, as well as by society. Consequently, a woman tends to ignore or hide her drug problem.

Families and friends compound the problem by helping to hide it in their efforts to avoid the shame and social embarrassment that go with women's substance abuse.

A number of suggestions were made for easing the stigma and creating an understanding atmosphere for the woman with substance abuse problems:

- The involvement of well-known and respected personalities who can discuss the problem and engender public empathy;

- Extensive use of television and radio talk shows, particularly during the day, to focus on women's problems and emphasize the need for early identification and treatment as important preventive health measures.

Since substance abuse can become a problem for any woman, at any age and in almost any environment, prevention also involves increasing an awareness of "positive health" and the negative potential inherent in the use of dangerous substances.

Specific suggestions included programs aimed at developing women's self-confidence, self-awareness, coping and survival skills. Programs are also needed which discuss nutrition, exercise and the components of health, foster better parenting skills, identify the warning signs of substance abuse, and encourage alternatives.

The need to reach "at risk" women--specifically those who are isolated, who are members of minority groups, or who are not likely to be involved with the traditional helping agencies--was emphasized repeatedly. Recreational alternatives, education and vocational training and the skills that might lead to meaningful employment seem to be lacking among "at risk" women, whether they are in rural areas, urban ghettos, or affluent suburbs. Programs to provide such options were urged for these groups.

Existing Efforts and Future Needs

While most states reported the existence of prevention efforts, few were geared to women's health issues or to women's substance abuse problems.

In some regions, efforts were described as "relatively limited to almost non-existent." In others, more activity was described, although efforts appear to be fragmented, uncoordinated, largely ineffectual, and hampered by inadequate funding.

States generally invest in public education efforts, with emphasis on public school prevention programs. Only some states have made particular efforts to alert women to the dangers of misusing prescription drugs and to reach the hidden drinker. A number of states reported public information programs aimed at women in child-bearing years. The potential damage to an unborn child caused by their abuse of alcohol or other drugs was the dominant theme. Several states have established "hotlines" to provide telephone information and counseling services. Since these have proven effective in reaching women in isolated, rural areas as well as women who need information but want to preserve their anonymity, the establishment of local "hotlines" throughout the country was repeatedly urged.

Washington State reported an unusual prevention/intervention project. Small grocery store proprietors, trained to notice substance abuse patterns and behavior, deposit literature into grocery bags. Similar training is offered to Tupperware and Avon representatives, who serve as auxiliary outreach and referral staff.

The needs cited throughout the reports, however, far exceed existing efforts. There were repeated suggestions for more effective use of the media, for more attention to the problems posed by alcohol and prescription drug use, for the development of more and better materials aimed at specific regional needs, for recognizing important cultural and language differences, and for more creative and intensive efforts to reach isolated women.

Necessary activities most consistently mentioned were:

- Compiling and widely distributing statewide resource directories to provide readily available, up-to-date information about treatment programs, mental health facilities, self-help groups, workshops and educational programs, child care, transportation, financial aid, legal assistance, and other services relevant to women;
- Involving respected public figures in citizen awareness efforts and using daytime radio and television to reach those who are most isolated;
- Educating employers about the problems of women and the signs of substance abuse; encouraging employers and labor unions to develop their own prevention and early identification/intervention/treatment efforts;
- Identifying women who are knowledgeable about women's health and substance abuse issues to speak to various community and women's groups;
- Involving those who are not addicted and who have developed effective coping mechanisms, to work with and assist those with potential or actual substance abuse problems;
- Providing greater recreational opportunities, particularly for teenagers and women in isolated areas, to promote alternatives to substance use;
- Improving coordination of the separate efforts of public and private groups.

Professional Training

In efforts to increase awareness among professionals who come in contact with women, physicians were particularly singled out.

Alliance participants were especially critical of the tendency of physicians to "help" women by prescribing tranquilizers or sedatives. By allowing automatic refills or renewing prescriptions over the telephone, dependency is encouraged. Warning is rarely given about the hazards of using multiple drugs and in combination with other substances. It was also felt that physicians often failed to identify alcohol or drug problems in women, and that they were not alert to other problems that confront many women, such as wife battering. Their lack of sensitivity can be traced to their medical education, where little emphasis is placed either on problems which have implications for the health of women or on alcohol and drug abuse. Physicians are taught to treat symptoms, rather than to identify underlying problems, and are conditioned to believe that women are not as psychologically "sound" as men, are inherently more dependent and likely to have emotional problems.

Deficiencies in existing medical education can be corrected by requiring medical schools to include women's health problems and drug and alcohol abuse in their curricula materials and by encouraging attendance at continuing education programs on these topics for physicians already in practice. If this

knowledge is required for Board Certification examinations or for State Certification, medical schools and medical societies will respond by providing necessary training opportunities and clinical experience. While this information should be part of the educational background of all physicians, it is particularly important for internists, family practitioners, gynecologists, obstetricians and psychiatrists--who are frequently consulted by women--and for emergency room medical staff who often see women at a crisis point.

The potential service role of pharmacists in education/prevention efforts was also specified. Pharmacists are in a unique position to identify women who refill prescriptions frequently, or who are taking drugs that may be cross-addictive. They also can distribute information about drugs, side-effects, and substance abuse.

The reports identified a general lack of awareness about the problems of women among all health professionals, not just among physicians, and called for the development of training programs for such personnel as nurses, counselors, psychologists, paramedics, and emergency room technicians. Because of the difficulties involved in physician-patient communication, these other health professionals often develop better rapport with women who find it easier to discuss problems with someone less imposing than a physician.

The content of training that would better equip health professionals to assist women includes such topics as women's

health, nutrition, sexuality, sensitivity training, as well as methods for assisting those with substance abuse problems. Other groups who should be alerted to women's problems include clergy, social workers, and teachers. Some states suggested efforts to provide referral information to housing managers, grocers, beauty shop operators, and others who meet with women on a regular basis. A number proposed special efforts to provide training for those within the criminal justice system--for police, lawyers, judges, parole and probation officers--about women's health and substance abuse problems.

According to the reports, responses to the NIDA-sponsored "Women in Treatment" program are varied. Some find it adequate for their training needs. Others feel its availability is too limited. A few said the approach is too "personalized" and does not provide sufficient specific and factual material or follow-up to evaluate its effectiveness.

Several states reported that Title XX money is being used to develop new courses in colleges and universities; while others reported success with regional training efforts, such as those of the Eastern Area Alcohol Education and Training Program and the Yale Drug Dependency Institute. Several states reported state-sponsored training programs in counseling, interviewing, and program administration techniques.

The reports identified a number of other specific training needs:

- Women need to be trained to enter the health systems agency network, particularly in positions where funding and policy decisions are made;

- Women need to be trained to serve on advisory councils, mental health boards, and other groups whose policy and planning decisions affect women;

- Bilingual women need to be trained to work in treatment programs;

- Volunteers need to be trained to identify women's problems and to help women resolve them;

- Training programs for women and about women should be widely available;

- Training focusing on the special needs of women is important in alcoholism treatment where, as one report stated, the prevailing attitude is "there is no difference; treat them just like men";

- Such resources as community colleges should be more widely used for training purposes;

- Training should provide facts and figures as well as needed experience, skills and techniques;

- Training should attempt to abolish traditional stereotypes and to sensitize people to their socio-cultural biases;

- Extensive efforts are needed to publicize, support and schedule training programs so they are available to more people and easily accessible.

MORE THAN DETOXIFICATION

While women make up more than half of the population of the United States, they do not account for half of those being treated for alcohol and drug problems--even though some estimates suggest that women's substance abuse problems may be as great as those of men.

The reports prepared by Alliance participants show wide variation in the percentages of women in treatment populations. One region reported, for instance, that the percentage of women in drug treatment programs ranged from 18 to 32 percent, and in alcohol treatment programs from 13 to 19 percent.

Even greater variation is shown in some of the state reports. In Kentucky, 28 percent of the drug clients and 15 percent of the alcohol clients are women. Comparable figures for Utah are 30 percent and 15 percent; for Maine 44 percent and 18 percent; for Montana 47 percent and 22 percent; and for Kansas 28 percent and 25 percent.

A number of reasons were offered for the inconsistent, often inequitable representation:

- It is easier for women to hide substance abuse, since so many are alone throughout the day.
- Women are often shielded by families and friends because of the stigma associated with substance abuse.
- Many avoid treatment because of the stigma, the sanctions associated with deviant behavior, and the absence of anonymity inevitable when entering a program for drug or alcohol abusers.

- Women are justifiably afraid they will lose custody of their children if they admit to a substance abuse problem by seeking treatment.
- The lack of child care makes it difficult for many to undergo treatment.
- Outreach efforts are often misdirected, e.g., five empty inpatient beds in one program quickly filled when designated for "women."
- Cultural and language barriers block minority women from seeking help.
- More affluent women seek help from private physicians.
- Women habituated to legally obtained prescription medications are often unaware of potential addiction.
- Many women do not feel safe entering treatment programs in depressed neighborhoods.
- Few services are available for women in rural areas.
- Programs run by men, primarily serving men, are threatening.

Too, throughout the reports were indications that existing programs only reach limited groups of women and do not address the full range of women's substance abuse problems.

In Florida, for instance, most women in drug treatment programs are young opiate abusers, not the middle-aged amphetamine and barbiturate users who account for the majority of drug-related emergency room visits and suicides in that state.

The Iowa report's profile of women in treatment also suggested a distinctly limited group:

- 44 percent were between 18 and 25 years of age.

- The mean level of their education was 10.7 years.
- 28 percent were employed, half only part-time.
- Nearly 38 percent reported polydrug problems, with amphetamines, opiates and barbiturates the most commonly used drugs.
- Nearly 60 percent had undergone prior treatment.

In West Virginia, 35 percent of the women being treated for alcoholism and 26 percent of those being treated for drug abuse had a ninth grade or lower level of education. Ninety percent of those in treatment for drug abuse and 23 percent of those being treated for alcoholism were not employed outside the home.

The reports also showed that the retention rate for women is low in many programs. Anxiety about children and families, the failure of programs to identify or aid with other problems, and the insensitive attitudes of male staff members and clients were among the reasons offered for this low retention rate. Particularly revealing was the almost 100 percent drop-out rate from inpatient facilities having primarily male staff.

Access to Treatment

In theory, at least, women have equal access to treatment. Yet, as one report observed, *"what is available in drug and alcohol treatment is typically not denied to women but is not specifically geared to their needs."* Child care, for instance, is rarely provided although this is a critical need for many women.

Also, the processes of detoxification or drying-out treat only the symptoms known as drug abuse or alcoholism, failing to touch the underlying problems that lead a woman to substance abuse.

If treatment ends with detoxification and a women is returned to the same environment and the same social milieu with unaltered stresses and frustrations, it is likely symptoms will recur. Faced once again with the same problems, she will again turn to alcohol or drugs in her efforts to cope.

Typical treatment for drug and alcohol abuse for women is limited and often ineffective because it ignores their physical, psychological and social needs. This realization led to strong recommendations throughout the reports for comprehensive and coordinated efforts to meet their total needs.

These include special attention to such medical problems that are frequently seen among substance abusers as malnutrition, gynecological difficulties and venereal disease; counseling and behavior therapy for the depressions, anxieties, frustrations and insecurities that lead so many to adopt destructive patterns; and development of vocational and job skills, as well as skills for getting along in society and learning to deal with such everyday problems as parenting and budgeting.

Throughout the reports, the dimensions of treatment were considered from many perspectives: strengths and

weaknesses of existing programs; ideal common elements for all treatment programs serving women; possible alternatives; and needs of such special groups as women in prison and the elderly.

The fact that many programs have little success with women substance abusers was offered as sufficient justification for rethinking approaches to the treatment of women.

It was noted, for example, that large numbers of men in drug treatment programs were referred there through the criminal justice system. As a result, treatment programs respond largely to the needs of these men, at the expense of other groups--including women--who may be equally in need of treatment and whose profiles may be quite different.

While a number of participants reported that activities in the women's service area have been included in 1977-78 state plans, the lack of monitoring or enforcement of Federal regulations was frequently cited as a major factor in the limited development of women's programs.

Several participants observed that many women might find treatment in Community Mental Health Centers preferable to treatment in conventional programs, since the term "mental health" provides a certain degree of anonymity. While these centers are required by law to provide drug abuse and alcohol treatment services, these only have to be offered if there are no other treatment facilities in a catchment area, a loophole that has the effect of permitting centers to refuse

services by referring women to the other facilities--regardless of whether the programs are acceptable to women.

Effective Programs

The reports did provide some notable exceptions to the generally gloomy portrayal of insensitive and inadequate programs. Brief descriptions of a few illustrate the scope of effort participants believed necessary for effective programs.

In California, more than two million dollars have been allocated to develop women's programs. These include: pilot projects to enable women in residential treatment to keep and care for their own children; provision of child care services; programs for pregnant addicts; and studies of the types of crisis situations that lead to polydrug abuse.

The city of Alexandria, Va., has developed programs for women focusing on such issues as employment and job-seeking skills, parenting, assertiveness training, and "coping." An "employee assistance program" is offered for city workers with substance abuse problems, and workshops on the specific problems and needs of women have been offered for local service, religious, and law enforcement groups.

In Michigan, W.O.M.A.N. (Women's Organization Moving Against Narcotics) provides a comprehensive treatment and advocacy/referral service for female addicts and their children. Located in a poverty-stricken inner-city neighborhood, the project uses low-dose, short-term methadone

therapy but also employs such less conventional approaches as relaxation therapy and biofeedback. Medical care is provided, along with skill building, counseling and job placement services, and efforts are made to improve parenting skills and rebuild relationships with family and friends.

Wisconsin has concentrated on programs for alcoholism and sponsored a statewide symposium on the fetal alcoholism syndrome dealing with the prevention, intervention, and treatment implications for both women and children.

In Missouri, counseling programs are located in real estate offices or adjacent to drive-in food franchise operations to ensure anonymity and confidentiality.

In Utah, an alcoholism recovery program emphasizes good nutrition and high protein diets, and on physical and mental fitness. Participation in such exercise and recreational activities as swimming and dancing are integral elements of therapy.

Minnesota has pioneered in the development of programs for women. One program, the Chrysalis Center for Women, began offering counseling for addicted women in 1972, and provides counseling for women by women, child care, advocacy services, employment and treatment programs. The state has provided legislative support for the development of a number of other women's programs. The Minnesota report also identified problems confronting treatment programs for women. A survey of all programs in the state, conducted

for the McKnight Foundation, identified problems found in both urban and rural areas.

For urban, metropolitan programs these included:

- Among underserved populations, a need to connect with other people "like them" and a lack of self-discipline for committing themselves to regular program participation;
- A lack of trust among the clients;
- Difficulty in providing access to other needed services;
- Financial problems, specifically in transportation, housing and child care;
- Sexism on the part of men residents in treatment facilities;
- Older women feeling out of place because of the predominance of younger women;
- A lack of support from family members, who may also need counseling, and friends.

Among the problems inherent in rural programs were:

- Distances, which make follow-up difficult;
- Fewer women complete treatment;
- Lack of personnel and financial resources in the programs;
- Denial, inertia, and non-compliance, leading to general unwillingness to do anything about a problem;
- Lack of a support system during and after treatment;
- Little community concern for the problem.

A number of other problems that make it difficult to provide treatment for women were identified throughout the reports. These included their poor self-concept, dependency,

sexual problems, lack of assertiveness, and medical problems causing poor health.

Program Components

The reports found, in general, that successful programs are comprehensive and responsive to individual needs, that they involve the social, family, environmental, emotional, behavioral, and physical aspects of a woman's life.

Since the reports and discussions had suggested some elements that make programs effective, members of the treatment workshop at the Alliance's concluding symposium, drawing on the submitted advice, developed guidelines for fundamental services that should be available to all women in need of treatment. They emphasized that these services need not be provided directly by a drug abuse or alcohol treatment program, but should at least by available through referral.

These fundamental services include:

--Child care, possibly provided by adolescents trained to care for children as part of a prevention program, by women in a residential program as part of their therapy and to assist mothers in outpatient programs, or by the elderly;

--Educational and vocational programs to develop job and job-seeking skills;

--Diagnosis and treatment of co-existing medical problems as well as such positive health measures as programs on nutrition and exercise;

--The provision of legal services utilizing women lawyers or paraprofessionals for those facing divorce or child custody difficulties;

--The use of women counselors and women staff members who may serve as role models, as well as peer group counseling and self-help techniques;

--The location of programs in non-threatening, anonymous locations, close to public transportation, and hours that are convenient to mothers and working women.

They also suggested approaches that may be useful for "high-risk" populations:

--The use of mobile treatment units, home visiting teams and telephone hotlines to reach rural women;

--Diagnostic and treatment programs focusing on alternative patterns of behavior for women in prison, as well as educational and vocational programs to provide these women with essential skills to re-enter society;

--The development of bi-lingual programs and the use of bi-lingual counselors to reach members of ethnic and cultural minorities;

--The development of programs that focus on potentials and strengths and emphasize survival and coping skills for young women;

--The provision of telephone counseling and information services;

--The passage of legislation that ensures that substance abuse is not considered prima facie evidence of child abuse for hidden abusers who often cannot be reached by conventional techniques.

The committee also designated the types of treatment facilities that should be available for women, and listed some special considerations.

Outpatient programs, for instance, should offer a number of options, including woman counselors, and should do research to determine which types are most effective with which women.

Also, alternatives should be explored, including the development of non-traditional and non-medical ambulatory detoxification services, or the location of outpatient facilities within mental health or counseling centers so a woman would not be identified as a substance abuser merely by walking through a door.

The need for halfway and quarterway houses was emphasized, as was the need for emergency shelters where women can seek assistance and respite in times of crisis.

Several participants questioned the validity of using confrontation techniques with women who need a "warm, supportive environment" where they feel safe. Trust, genuineness, respect and empathy were listed as counseling skills particularly effective with women in trouble.

The need for support systems and follow through to assist women throughout the treatment, rehabilitation and re-entry process was stressed throughout the reports. The development of effective support systems involves many of the suggestions throughout this report; the coordination of services, the development of resource directories and referral networks, the close cooperation of public and private agencies at the national, state, and community levels.

The reports consistently identified several treatment gaps: the lack of programs to aid women who are prescription drug abusers and/or polydrug addicts; the absence of programs for addicts in prisons; and the lack of programs for elderly abusers.

Despite the high incidence of problems with prescription drugs, few programs provide assistance for women with these problems. This may be because these women typically seek help from private physicians, who frequently fail to recognize the problem--which may have been initiated through legally obtained prescriptions--or because the problem is compounded by the use of alcohol and/or other drugs, creating a polydrug or cross-addiction problem.

The Iowa report documented the high incidence of substance abuse among women in prison, showing that 13.4 percent classified themselves as "heavy" drinkers and that more than 70 percent had a history of illicit or prescription drug abuse. Women in prison typically have limited education

and no job skills, a long history of deviant behavior, and a long history of substance abuse. Several reports showed that the recidivism rate among these women is disproportionately high and urged early intervention and treatment programs emphasizing behavior modification. These women also have a variety of other health problems that need care and all the rehabilitation and support services recommended for women who are not incarcerated.

Few states reported any formal treatment programs for women substance abusers in prison, though most noted that men with substance abuse problems routinely are sent to facilities that offer special treatment programs.

The elderly substance abuser presents unusual treatment problems. Sometimes substance abuse develops because of the tendency of nursing homes and even families to keep the elderly slightly intoxicated or heavily medicated to assure tranquility, sometimes through misuse of a variety of prescription medications, and sometimes through their own desire to escape a dreary existence.

Suggested solutions included the use of home nurses or outreach programs to assess the medication problems and assure that the elderly understand how and when to take medications. Also, differences in rates of drug metabolism in the elderly requires physicians to use more sophisticated prescribing techniques than are now typical.

It was suggested that the general health of elderly women might be noticeably improved if they were provided a useful role in the community. Their skills could be utilized in hobbies or crafts, or assisting in child care and school programs.

Throughout the reports, great emphasis was placed on the need for effective, outside program evaluation. Thereafter, useful findings should be made widely available to other programs in order to assure better communication regarding the kinds of treatment which are found to be most effective.

CHANGES ARE NEEDED

Efforts to enhance good health among women and to help those with alcohol and drug abuse problems will require alterations in the existing system to coordinate resources, and to assure program continuity and administrative effectiveness.

The most persistent recommendation throughout the Coalition's reports calls for the provision of comprehensive health services for women through better coordination of existing services and resources. As currently provided, services are fragmented, sometimes overlapping but more often leaving wide gaps. They are neither comprehensive nor widely available, and show a tendency to "treat" problems in isolation, typically ignoring total needs.

In some parts of the country, few services are available. In many rural areas, there are none. But even where services are theoretically available, they are not always accessible because of the location of the program or its hours of operation. One report describes restrictive clinic hours that make it difficult, if not impossible, for women to obtain such services as routine immunizations for their children. Another described programs located in dangerous neighborhoods which women were reluctant to use because of fear for their safety.

Also, because guidelines and regulations frequently conflict, programs may be available to some women, but not to

others. A number of states reported that alcohol treatment programs do not accept women on methadone maintenance, and that Community Mental Health Centers are not required to accept women with alcohol or drug problems if there are alcohol or drug treatment programs within the catchment area.

Since a number of studies suggest that cross-addiction is a significant problem for women--one survey of women alcoholics showed that 80 percent took other drugs as frequently as they used alcohol--the need for programs that addressed both problems was stressed. Alliance participants emphasized the desirability of better coordination at the state and Federal levels, particularly in funding criteria and allocation.

The reports charged that typical drug abuse and alcohol treatment programs fail to treat other medical problems. This was attributed to the very limited orientation of treatment programs--alcohol treatment programs deal only with alcoholism, drug abuse programs with drug abuse--but also to the fact that programs operate in isolation, with little awareness of other available resources and little referral experience. This deficiency emphasizes the need to develop comprehensive resource directories listing programs and facilities through which women can receive help, along with such essential information as their requirements and hours of operation.

Participants also suggested that each state develop some mechanism responsible for coordinating services. One

persistent suggestion called for the establishment of a full-time position for an individual to be authorized to conduct a state-wide assessment of women's needs, for identifying resources, and for developing the cooperation necessary to provide comprehensive health care.

Louisiana provides an example of one useful type of coordination required. There, the position of "Coordinator, Programs for Women" was established in 1975. The coordinator's task has been to serve as an advocate for women's concerns and to coordinate public and private efforts to meet their needs. The coordinator reports that her efforts have resulted in:

- The inclusion of stated objectives for women, with action steps, in the state plans developed for both NIDA and NIAAA;
- An increased awareness on the part of the state office staff and throughout the statewide clinic and drug center systems of the need to emphasize women's concerns in alcohol and drug abuse;
- Extensive use of the media to increase public awareness of women's concerns and activities;
- Sponsorship throughout the state of "Women and Stress" conferences that incorporate alcohol and drug problems into programs of broader interest to women;
- Through cooperation with the State Bureau of Women, development of educational programs for prison, native American, and other women's groups;
- Approval to design and provide consciousness raising sessions on women's problems to all clinic staff members in the state;
- The promise of cooperation from legislative and Congressional representatives.

Broad Involvement Needed

The task of developing a coordinated and comprehensive service network is formidable, since so many groups and agencies at all levels are involved and concerned with women's issues. To provide some idea of how broad this involvement is, some of the resources--both actual and potential--identified by participants included:

- At the Federal level, the Department of Health, Education, and Welfare, especially such agencies as the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Mental Health, the National Institute on Aging, the National Institute on Child Health and Human Development, the Office of Human Development, the Office of Education, the Health Care Finance Administration, and also the appropriate units of the Departments of Housing, Justice, Labor, and Transportation;

- Such national professional organizations as the American Medical Association, the American Psychological Association, the National Association of Social Workers, and the American Public Health Association;

- Religious and church groups, such as the United Methodist Women, the American Baptist Convention, Catholic Charities, and B'nai B'rith;

- Voluntary groups including the Salvation Army, the National Council on Alcoholism, the YWCA, the League of Women Voters, and Volunteers of America;

- Such self-help groups as Alcoholics Anonymous, Al-Anon and Al-a-Teen, and Women for Sobriety;

- Women's groups, including the National Organization of Women, the Women and Health Roundtable, and the Commission on the Status of Women.

The diverse membership on the Alliance's advisory board suggests the broad range of groups with a demonstrated interest in women's health and women's substance abuse problems.

Administrative Funding Problems

A specific concern among participants was the need for a stable source of funding to provide necessary program security and to provide continued encouragement for developing more creative approaches to assisting troubled women. One report commented on the difficulty in obtaining funds when observed needs have not first been demonstrated and specific techniques for meeting them have not been proven.

"This problem becomes cyclical when programs must often spend much energy on survival issues with little time left for the more sophisticated issues of researching and of programming for specialized needs; without the research and programming, no resources will support specialized services within existing programs."

There was also a concern about simply requesting funds "earmarked for women" when none are "earmarked for men." Suggestions were made that distributions of funds might be predicated on better definitions of "equalization," "appropriateness" or "vulnerable populations' needs."

Closely linked with the problem of stable funding was the concern that programs are not funded to provide many necessary services for women with substance abuse problems--such services as child care, housing, transportation, vocational

training, education, psychotherapy and related medical care. Often financial assistance is not available for these services, often women who need them do not qualify.

It was noted that insurance companies resist coverage for alcohol and drug treatment or for the other counseling services that are necessary for successful treatment. The same is true of Federal financial aid programs, where requirements and restrictions limit availability of treatment and services.

The reports advocated concerted efforts to involve private insurance carriers and such Federal assistance programs as Medicare, Medicaid and Title XX in providing financial assistance for treatment and related support services, and also to explore the possible role of private foundations in this area. Also, it was emphasized that proposals for National Health Insurance should be scrutinized to assure inclusion of coverage for issues relating to women's health needs.

Throughout the reports, suggestions were made for improving planning and administrative effectiveness of women's service programs. As one state observed, *"it should be noted that many state systems cannot report in any adequate way the number of programs funded in their state, the number headed by women, or the number of programs targeting on women's needs."*

Staffing Patterns

The absence of women in administrative, planning and staff positions was cited repeatedly.

There were some exceptions, including the statewide coordinator in Louisiana. Several other states reported that similar positions have been created (but not necessarily filled) to deal with women's issues. A woman administers the alcoholism program in one state. Several other states reported a good representation of women in staff positions.

But the more common pattern was an erratic application of affirmative action. For example, although most states have advisory councils, some have only one to three woman members of boards numbering 20 or more persons. Several states charged that veterans preference rules in hiring effectively thwarts affirmative action. Furthermore, since women do not qualify for the educational benefits essential to advancement unless they are already in administrative positions, fewer women are able to move into high level administrative roles--unless they are willing to meet educational qualifications at their own expense.

Reported staffing patterns showed that women are underrepresented at many levels, except the clerical. In Georgia, for instance, two out of nine administrative staff members and only five of 26 treatment program administrators are women. Rhode Island has one female and seven male substance

abuse abuse program directors, five women and four male Treatment Alternative to Street Crime administrators, and 11 women of a total of 39 are program directors. By contrast, 47 percent of the Iowa Drug Abuse Authority staff members are women, including 38 percent of those in professional or managerial/executive-level positions. Women, always well represented in clerical positions, accounted for 100 percent of these staff positions in some states.

Generally, reports suggest that programs are more responsive to women's needs when women are actively involved in their planning, administration and implementation. Also, a study in one state showed that women were more likely to seek treatment in programs in which women are well-represented on the staff. Women had a high drop out rate in residential treatment programs in which professional staff were predominantly male. Yet, some women have an historical difficulty difficulty relating to other women, and prefer programs where there is a balance of male and female staff. The differences suggest the need for flexible staffing patterns and the greater availability of programs with different types of staffing ratios.

The reports also showed that programming is more responsive to actual needs when planning and advisory groups include community representatives, rural women, and members of ethnic and cultural minorities. One state reported the effective development of acceptable alternatives for rural women because of their representation in the planning and advisory

process. The need to include teenagers and the elderly so as to reflect the differing needs of different age groups was also emphasized. The formation of such groups with deliberately diverse representation was a consistent recommendation throughout the reports.

Planning Policies

The lack of specific policy for women's treatment in many states was cited. While most state plans officially recognize women's needs, the policy of "equal access" rather than programs specifically tailored to their needs appears to be more common.

As the Iowa report noted, the state programs comply with the funding criteria of the National Institute on Drug Abuse, the rules and regulations of the Food and Drug Administration, and the licensing standards of the Iowa Drug Abuse Authority, providing a relatively restrictive program definition.

However, since past NIDA guidelines have not required or monitored planning and programming for women, minorities, youth or the aged, the report continued, no special programs have been developed with the result that *"special needs of women and minorities are not being met uniformly but are dependent upon the program and the individual counselor's sensitivity to these needs."*

While a number of states reported programs for women in such women-only areas as rape counseling, abortion, and wife

battering, wide differences in commitment were apparent throughout the reports.

Rhode Island, for example, states that no policy or needs assessment addresses women's issues. In New Jersey, the Single State Agency is committed to the development of women's programs with a full-time coordinator for women's programs and a designated advisory group. In Georgia, services are available but no priority is given to special programs, and in South Carolina women have been designated as a "special target group" but no funds have been provided for program development--a consistent complaint throughout the reports.

North Carolina has no formal policies for women substance abusers, but does have a system for collecting data on women--an essential step in assessing their needs. In Oregon, women are singled out as a special population in the alcoholism plan but, even though the drug authority says that women have problems equal to those found among men, no special program objectives have been established for women.

The erratic planning patterns described throughout the reports emphasize the need for planning that specifically assesses and addresses the needs of women.

The changes proposed by Alliance participants do not always require the development of new service systems. Rather, they call for new approaches, new ways of thinking, and new ways of working together.

In most areas, service systems are already in place, but are not being used efficiently or effectively to assist

women with drug and alcohol abuse problems. Through increased communication and coordination, both among and within the public and private sectors, existing energy and resources can be used more creatively and more flexibly to better meet the total health service needs of women.

SOME SUGGESTED REMEDIES

Discussions at Alliance meetings and submitted State and Regional reports provided the basis for the following suggestions to resolve some of the problems they had defined.

It must be emphasized that their suggestions reflect a "grassroots" perspective. They were drawn from local solutions for locally defined problems. Thereafter, they were amplified and developed to provide guidance for Federal and other efforts to respond to the needs of women. Some of the suggestions are global, reaching far beyond the drug and alcohol problems of women; others are quite specific to these problems. Some call for action at the Federal level; others at the state or local level.

In this section, suggestions are grouped, insofar as possible, according to problem areas and accompanied, whenever appropriate, by a statement indicating where the action should be initiated and under what authority.

Since a number of laws affecting women's health issues and drug and alcohol problems are due to be reviewed during the current session of Congress, many of the suggestions could be included in the legislative considerations. Those laws scheduled for renewal include:

--PL 92-255 (amended by PL 94-371) the Drug Abuse Office and Treatment Act.

--PL 93-641, the National Health Planning and Resource Development Act.

--PL 94-63, the Community Mental Health Centers Act.

--PL 92-603, the Social Security Act and Amendments, particularly amendments to Title XVI and Title XX.

In reviewing the suggestions, it might also be useful to consider existing law with particular implications for women, their health and substance abuse problems, and for addressing the many related issues. These include:

--The Food, Drug and Cosmetic Act of 1951.

--The Narcotic Control Act of 1956.

--The landmark case of Roberson v. California, 1962, in which the Supreme Court declared addiction to narcotics is an illness and that criminal punishment for such addiction violates the 8th Amendment.

--PL 91-513, the Comprehensive Drug Abuse Prevention and Control Act of 1970.

--PL 92-73, Title II, of the Controlled Substances Act.

--PL 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

--PL 94-581, Veterans Omnibus Health Care Act of 1976.

--PL 94-293, Domestic Voluntary Service Acts Amendments.

--PL 94-230, The Rehabilitation Act Extension of 1976.

--PL 93-647, The Social Security Act Amendments.

--PL 93-641, The National Health Planning and Resource Development Act of 1974.

--PL 91-177, Economic Opportunity Act Amendments of 1969.

--PL 91-211, Community Mental Health Center Amendments of 1970.

--PL 91-296, Medical Facilities Construction and Modernization Amendments of 1970.

--PL 94-237, Amendment to Drug Abuse Act of 1972.

--PL 91-527, The Drug Abuse Education Act of 1970.

--PL 91-644, Omnibus Crime Control Act of 1970.

--PL 92-157, Comprehensive Health Manpower Training Act of 1971.

--PL 92-255, Drug Abuse Office and Treatment Act of 1972.

--PL 92-293, Narcotics Addict Rehabilitation Act Amendment of 1972.

--PL 92-424, Economic Opportunity Act Amendments of 1972.

--PL 92-603, Social Security Amendments of 1972.

--PL 92-381, Juvenile Delinquency Prevention Act.

--PL 93-112, Rehabilitation Act of 1973.

--PL 93-113, Domestic Volunteer Service Act of 1973.

--PL 93-203, Comprehensive Employment and Training Act of 1973

--PL 93-222, Health Maintenance Organization Act of 1973.

--PL 93-253, Amendment to the Reorganization Plan No. 2 of 1973.

--PL 93-353, Health Services Research, Health Statistics, and Medical Libraries Act of 1974.

--PL 93-415, Juvenile Justice and Delinquency Prevention Act of 1974.

--PL 93-516, Rehabilitation Act Amendments of 1974.

--PL 93-619, Speedy Trial Act of 1974.

--PL 93-647, Social Services Amendments of 1974.

--PL 94-63, Community Mental Health Center Amendments of 1975.

--PL 94-230, The Rehabilitation Act Extension of 1976.

--PL 94-460, Health Maintenance Organization Amendments of 1976.

--PL 93-83, Crime Control Act of 1973.

--PL 93-86, Agriculture and Consumer Protection Act of 1973.

--PL 93-247, Child Abuse Prevention and Treatment Act.

--PL 93-281, Narcotic Addict Treatment Act of 1974.

--PL 93-282, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974.

--PL 93-348, National Research Act.

--PL 93-383, Housing and Community Development Act of 1974.

--PL 93-422, Alcohol and Drug Abuse Education Act Amendments of 1974.

--PL 93-644, Headstart, Economic Opportunity, and Community Partnership Act of 1974.

--PL 94-371, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1976.

--PL 94-401, Social Security Act Amendments of 1976.

--PL 94-503, Crime Control Act of 1976.

--PL 95-115, Juvenile Justice and Delinquency Prevention Act Amendments.

The multitude of Federal departments and agencies, state agencies and voluntary groups currently involved in or with potential interest in these problems also needs to be examined. Those named specifically in the suggestions offered by Alliance participants are only a beginning, since it is apparent that the issues involved are so pervasive that virtually no public or private agency or group can remain unaffected.

General Suggestions

Many suggestions made by Alliance participants were general in nature. They addressed the importance of coordinating and strengthening both Federal and private sector efforts to promote better health for women, and identified some fundamental changes that are needed to assure the success of these efforts.

o A Federal interdepartmental task force is needed to focus on the health needs of women, particularly those with substance abuse problems.

Among the issues this task force needs to consider are:

a. policy conflicts in proposed or enacted laws, regulations, and guidelines that affect the provision of consistent services for women "disabled" because of drug abuse or alcohol problems.

b. disparate Federal funding criteria that affect the availability of support services essential to the treatment of women with substance abuse problems.

c. the review of research that has identified factors affecting the physical stability and emotional health of women so that these findings can be incorporated into the design of prevention, education, and treatment programs.

d. a review of current prevention/intervention/education efforts to assess their effectiveness in alleviating problems confronting women.

e. a review of current Federal reporting requirements to reduce overlap, duplication, and administrative burdens on state and local jurisdictions.

f. mechanisms for increasing collaborative activities and coordinated services for women.

This task force should be established by Executive Order, as a Domestic Policy Group Working Committee. Membership should include, but not be limited to: National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Mental Health (NIMH), National Institute on Aging (NIA), National Institute on Child Health and Human Development (NICHD), Food and Drug Administration (FDA), Office of Human Development (OHD), Health Care Finance Administration (HCFA), Health Resources Administration (HRA), and Office of Education (OE) from Department of Health, Education and Welfare; Law Enforcement Assistance

Administration (LEAA), and the Bureau of Prisons (BOP) from the Department of Justice; Education Training Administration (ETA) in the Department of Labor; Community Planning and Development (CPD) from within the Department of Housing and Urban Development; and the Urban Mass Transit Administration (UMTA) in the Department of Transportation. Based on considerations and findings of the group, individual task force members should define their agency's responsibility in resolving problems that impact on the health of women. (Examples: the development of alternative education programs by OE to counter the school dropout problem; the provision of recreational space in public housing funded by HUD to ease stresses created by overcrowded living conditions.)

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o Agencies and divisions within the DHEW need to define responsibilities for providing health care to women consonant with the coordination of efforts at both national and state levels for the delivery of comprehensive and cost-effective health care services

While primary responsibility for coordination within HEW should come from the Secretary, authorization is provided both by PL 94-371 and by the Executive Reorganization Act, as amended in 1977. Precedent for such coordination can be found in the language of PL 94-103, the Developmentally Disabled Assistance and Bill of Rights Act, in which states are provided assistance in developing a full range of services, provisions are made for including private sector representatives, and appropriate treatment rights are assured. Also, the "Standards for Community Agencies Serving Persons with Mental Retardation and other Developmental Disabilities", developed by the Joint Commission for the Accreditation of Hospitals, establishes measures for development of service delivery systems designed to provide comprehensive and cost-effective health care services.

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o The concept that drug and alcohol abuse are chronic, if temporary, disabilities needs to be universally accepted

in order to:

a. legitimize their treatment in the total health system.

b. assure that treatment is covered by third party payers.

c. establish treatment and staffing standards.

d. establish after-care techniques.

This concept should be incorporated in all relevant Federal guidelines as well as promulgated by such groups as the Joint Commission on the Accreditation of Hospitals and the American Medical Association. Enforcement of HEW guidelines for the handicapped should reflect this interpretation, as should considerations of National Health Insurance Coverage.

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o Standards are needed to govern the use of tranquilizers and other mood-altering drugs among women in prisons and in homes for the elderly.

Such standards should be developed by the Food and Drug Administration and incorporated in Bureau of Prisons regulations and HEW and Joint Commission on Accreditation of Hospital (JCAH) guidelines.

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o Existing legislative mandates for programs that provide medical and social services need to be reviewed to identify and remedy exclusionary language that inhibits or denies access to assistance. Specific examples are:

a. provisions in Title XX of the Social Security Act that restrict homemaker services for the "potentially dependent and mentally ill."

b. amendments to the Community Mental Health Center Act that permit denial of drug and alcohol treatment "if there is another facility in the catchment area."

These reviews should be authorized by the Secretary of HEW and should include, but not be limited to: vocational, education and vocational rehabilitation programs, SSI, Medicaid, Medicare, Title XX of the Social Security Act and, the Community Mental Health Center Act.

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o Evaluation and monitoring components need to be built into all prevention, treatment, and training efforts. Impartial review is essential to assure that:

a. ineffective programs are either modified or discontinued.

b. successful programs are continued and, if indicated, expanded.

c. the continuity of promising pilot projects is assured.

Requirements for evaluation and monitoring should be incorporated into appropriate guidelines and regulations of NIDA, NIAAA and NIMH, with regular oversight by the Congress.

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o Local zoning laws need to be amended so that the development of certain types of housing and treatment facilities, such as halfway houses, is not prohibited. (Example: laws in Hawaii that limit to five the number of unrelated persons dwelling in the same household.)

Uniform funding criteria and guidelines should be developed jointly by the Housing and Urban Development and Department of Health, Education and Welfare to encourage local authorities to re-examine restrictive laws.

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o The resources and capabilities of the private, voluntary sector are fundamental to the resolution of women's health problems. The type of activities that can best be carried out by the private sector include:

a. advocacy/education for civic and professional organization members, local media, citizen planning boards, and legislators.

b. support for community prevention activities through such mechanisms as developing job and recreation programs for teenagers, and establishing child care services and crisis support shelters.

c. provision of financial support for research.

Private sector agencies and groups should coordinate their efforts to assist women in order to enhance individual programs and to prevent duplication. Federal funds for community and constituent assistance are available to support private sector programs and should be fully utilized. Additional funds for such efforts are available through PL 95-115, amending the Juvenile Justice and Delinquency Prevention Act of 1974, the Alcohol and Drug Abuse Education Act of 1970, and the Comprehensive Employment and Training Act.

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Data Needs

Alliance participants repeatedly cited the lack of information as a barrier to the development of effective programs for women. This deficiency produced a number of suggestions aimed at gathering the required information and assuring that useful information is widely available to those who need it.

o A comprehensive data system, combining the separate computerized systems of all health-related institutes and agencies within the Department of Health, Education, and Welfare, is needed to:

a. provide Federal, state, and other jurisdictional programs and departments with information for planning and monitoring.

b. assure that appropriate data is available for health needs assessments by local Health Systems Agencies under the National Health Planning and Resource Development Act of 1974.

c. provide a sound data base for development and implementation of a National Health Insurance Plan.

This data system should contain demographic and epidemiologic information, health and vital statistics, as well as research data--including sociological, anthropological, psychological and educational findings related to health issues.

The Secretary of HEW should expand current regulations to require the development of a comprehensive, department-wide data system.

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o The ten regional offices of the Department of Health, Education and Welfare need to be strengthened to serve as more effective extensions of the national office. As part of this strengthening, clearinghouses need to be established

within each office, with computer terminals that are available to state and local jurisdictions, to gather and disseminate the following materials within the region:

a. information on past and current research in the general area of women's health.

b. epidemiological data about women and substance abuse.

c. public information and prevention materials specific to the needs and problems of women in the region.

To permit this, Sections 305 and 306 of PL 93-353, the Health Services Research, Health Statistics and Medical Libraries Act of 1974, should be amended to permit retrieval centers in regional HEW offices as well as or in place of academic institutions only, and to permit the use of newer technology other than "forms" in compiling health data. Also, "illness and disability" indices should be developed to identify trends and make projections about women with drug and alcohol dependencies.

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o Requirements for the collection of vital statistics, for the recording of emergency room reports, and for admitting diagnoses need to be expanded to include secondary causes, particularly when drug and/or alcohol use is involved.

These requirements should be written into data-gathering regulations of appropriate units of the Public Health Service. Such organizations as the American Medical Association should devote attention to training physicians to seek and define secondary causes and problems which are essential to the provision of adequate health care and to identity "hidden" problems, like alcoholism.

FUNDING

Beyond the frequently expressed suggestion that more funds are generally needed to support treatment and prevention programs for women, some particular problem areas were recognized and specific suggestions offered.

o Federal funding criteria need to be reviewed to assure that assistance is uniformly available to women with substance abuse problems, with particular attention to:

a. supportive services--especially the provision of child care--essential to the treatment of women.

b. provision of funds for counseling and treatment of other family members, when necessary.

c. inclusion under Medicare of coverage for outpatient treatment for drug abuse and alcohol problems.

d. assurance that women treated for their "disability" under the provisions of one program do not lose eligibility under another program because of treatment.

The Secretary of HEW should request a review of all assistance programs, with particular attention to age, sex, and disability requirements, to be followed by appropriate amendments to Federal funding criteria to remedy existing conflicts and assure that assistance is made available. Further, PL 94-371 should be amended to provide grant assistance for counseling and treatment of other family members affected by drug abuse and alcoholism.

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o Uniform insurance codes are needed to:

a. require that state licensed health insurers designate drug and alcohol addictions as chronic diseases.

b. provide insurance benefits for both hospital and outpatient counseling and medical care for such disabilities.

Such codes should be developed by the American Bar Association's Uniform State Law Commission which could encourage states to adopt these codes. This coverage should also be specified under provisions of PL 93-647, the Social Security Act, so that Federal medical assistance programs provide the lead for private insurance carriers.

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o Funds derived from state alcohol tax revenues need to be accepted as "matching funds" for alcohol prevention and treatment project money.

This stipulation should be incorporated into the Federal funding criteria of the Department of HEW and into NIAAA guidelines.

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RESEARCH

Suggestions for research on women, their health needs, and their substance abuse problems focused not only on individual issues for which the answers are not yet known but also on the importance of coordinating and consolidating research efforts and assuring that research findings are made widely available so they may be utilized in prevention and treatment programs.

o The Institutes within ADAMHA need to coordinate their own research activities and to work closely with the various Institutes within NIH on specific research projects involving women's health and substance abuse issues.

Authorization for such coordination is provided under the Reorganization Act of 1972. The Secretary has internal authority within HEW. OMB may empower additional changes.

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o Expanded research on women's substance abuse issues is needed, including studies to:

a. assess the relationship between such factors as isolation, family violence, moving, divorce or separation, employment, and education, and substance abuse problems.

b. identify specific "risk factors" for such vulnerable groups as teenagers, pregnant women, minority women, housewives, single mothers, divorced or separated women, women living in urban ghettos or rural areas.

c. identify the warning signs of actual or potential substance abuse to permit identification and intervention.

d. identify coping techniques for crisis situations which may be attendant to marriage, parental responsibilities, unwanted pregnancy, abortion, rape, menopause, divorce, widowhood, or major surgery.

e. document the impact of advertising and marketing techniques on the use of alcohol and prescription and over-the-counter medications.

f. identify relationships between hormonal changes and the use and effects of drugs and alcohol at different stages in a woman's life.

g. determine the relationship of the menstrual cycle to drug and alcohol metabolism.

"If we listen attentively, we shall hear amid the uproar of empires and nations, the faint fluttering of wings, the gentle stirring of life and hope. Some say this hope lies in a nation, others in a man. I believe, rather, that it is awakened, revived, nourished by millions of solitary individuals whose deeds and words every day negate frontiers and the crudest implications of history."

- Albert Camus

h. define both the psychological and physiological impact of substance use on teenage girls.

i. determine how cultural patterns and beliefs influence a woman's use of drugs and alcohol.

j. examine the role of prescribing patterns in the abuse of prescription drugs.

Funds to support research on women's substance abuse and health problems should come through the Institutes within ADAMHA and NIH, with authorization for priority efforts provided by PL 94-371 and appropriations under Section 503 of PL 94-237. Section 3(a) of PL 94-230 - The Rehabilitation Act Extension of 1976 also provides appropriations for relevant research.

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o Longitudinal studies are needed to determine the impact of maternal substance abuse on the physical, psychological and intellectual development of children. Specifically included in these studies should be:

a. offspring of alcoholic mothers, and particularly those children who exhibit the fetal alcohol syndrome.

b. children born addicted to heroin or methadone.

c. children born to women who used tranquilizers, sedatives, mood elevators and related prescription drugs during pregnancy.

d. children whose mothers were heavy marihuana users.

These studies should be a collaborative effort involving OCD, NIDA, NIAAA, NIMH, NICHD and OE. Authority for such efforts is found in provisions of PL 94-371 and appropriations within the enabling legislation for all named agencies. Certain projects would be appropriate for funding under the Social

Security Act, Title V, Section 508 - "Maternity and Infant Care", which place emphasis on high risk pregnancies.

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o Women of child-bearing ages need to be included in drug and alcoholism studies so that the physiological effects of these substances can be fully evaluated.

Guidelines and techniques for conducting such studies should be developed jointly by FDA, NIDA, and NIAAA. Where possible, FDA protocols should then be amended accordingly.

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o Research findings need to be widely publicized and disseminated so that useful new information can be incorporated into treatment, training, prevention, and public education programs for women with substance abuse problems.

Agencies sponsoring research should be responsible for assuring that results are shared with appropriate programs. The proposed clearinghouses for the 10 regional offices of the Department of Health, Education, and Welfare would expedite this process. The Rehabilitation Act of 1973 provides for the development of new and innovative methods of applying new technology and knowledge for rehabilitation problems. Under this specification, annual reports of research findings should be required of the sponsoring agencies so that these findings can be utilized in related programs.

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o In rating contract and grant submissions on women's issues, qualified women researchers should be given preference points, analagous to Veteran's preferences in hiring.

Authorisation for such preferential treatment is provided by the precedent of such affirmative action plansand Title VII of the Civil Rights Act of 1964

Prevention and Public Information

Many suggestions highlighted the desperate need for new and imaginative approaches to reach the most vulnerable groups and to provide alternatives so that women will not automatically turn to drugs and alcohol as "a crutch" or means of coping. Suggestions also reflected the concepts that successful efforts must respond to local needs and involve private and voluntary groups at the local level, but that there are individual, professional and Federal responsibilities in this area as well.

o Local citizen and voluntary groups need to coordinate their efforts to more effectively address women's health issues and substance abuse problems. Their activities might include:

a. encouraging participation of such groups as schools, community colleges, businesses, industries, unions, women's clubs, church groups, parent-teacher associations, youth and senior citizens groups in prevention and public information programs.

b. developing and sponsoring recreational programs, particularly for teenage girls and for elderly women.

c. establishing a speakers bureau knowledgeable about the problems and needs of women and available to both public and private groups.

d. sponsoring and participating in daytime television and radio programs featuring well-known and respected

personalities who could target these issues.

While these efforts must be local to be effective, impetus should be provided by Single State Agencies. PL 94-293, the Domestic Voluntary Service Act Amendments, vests in Vista and Action the authority to provide stipends and training for voluntary community assistance programs, and specifies drug and alcohol abuse programs.

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o The public needs to be educated about drugs, particularly in such areas as:

a. the physiological dangers inherent in the use and misuse of barbiturates and tranquilizers.

b. the effects of combining prescription medications with alcohol.

c. the need to question physicians about prescription medications and to understand the purpose of medication, the dosage, and possible side effects or contraindications to use.

The primary responsibility for this type of education rests with individual physicians and with pharmacists who fill their prescriptions. State and local medical and other professional associations as well as drug manufacturers should share responsibility for consumer education. NIDA, NIAAA, and FDA should serve as a resource and should provide information and education materials to the media and to physicians and pharmacists, if requested.

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o Both written and audio-visual public information and prevention materials on women's health issues and substance abuse problems are needed. These materials should:

a. avoid scare tactics while explaining known hazards.

b. be available in the languages of indigenous populations and sensitive to ethnic, cultural, and socio-economic differences and pressures

c. reach such specific "high risk" groups as school children, teenagers, and pregnant women.

d. focus on such positive concepts as elements of good health and decision-making techniques.

Funds for the development and distribution of these materials should be available through NIDA and NIAAA and through the Office of Education under the Alcohol and Drug Abuse Education Act of 1970. Funds for prevention initiatives are also available through PL 95-115, amendments to the Juvenile Justice and Delinquency Prevention Act of 1974.

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o Businesses, industries and labor unions need to provide prevention and counseling programs in the area of substance abuse, with referrals for treatment if indicated.

Responsibility for encouraging individual businesses, industries and unions to recognize the need for and provide this type of assistance should be assumed by such groups as the U.S. Chamber of Commerce, the American Association of Manufacturers, and AFL-CIO. Unions might seek to assure such programs in their collective bargaining sessions.

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EDUCATION AND TRAINING

Because of the widespread concern among Alliance participants that few of the professionals who work with women--including physicians--have adequate training about the causes and implications of women's substance abuse, suggestions for increased education and training were

universal. The need for programs to provide women with skills in such general areas as survival and problem solving and in such specific areas as parenting was also widely recognized, as was the need to provide children and teenagers with a more meaningful education, especially in the vulnerable junior high years.

o Current requirements for Federal aid to medical schools need to be revised in order to provide incentives to:

a. increase the course hours in psychopharmacology and pharmacology required for a medical degree.

b. offer courses on the health implications of drug and alcohol abuse, sensitive to age and gender differences.

c. review existing course materials and methods of presentation to reduce or eliminate sex bias.

Although prime responsibility for reviewing and revising medical school requirements and curricula rests with individual medical schools and with such groups as the American Medical Association and the American Association of Medical Schools, HEW should provide financial incentives, either by providing additional funds to facilitate the review and changes or by withholding funds if changes are not made, to expedite the process.

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o Nursing, social work, public health and education schools, as well as such training programs which exist for police academies, need technical assistance to develop programs on women's health and substance abuse issues.

Technical Assistance should be available through such Federal jurisdictions as the Public Health Service, the Office of Education and the Law Enforcement Assistance Administration, and through such relevant professional groups as the American Medical Association, and the American Public Health Association.

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o As a prerequisite for certification or licensing, appropriate state authorities need to require the completion of at least one comprehensive course on women's drug and alcohol problems and related health issues. Required workshops, seminars and continuing education programs are also needed for professionals and paraprofessionals who come in contact with women who have substance abuse problems.

The American Medical Association, American Nursing Association, American Public Health Association, National Association of Social Workers and American Psychological Association are examples of organizations that should be involved in professional upgrading efforts. Professional schools should look to PL 94-63, Community Mental Health Amendments for training funds.

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o The role of the junior high school and its curriculum need to be thoroughly re-evaluated to assure its relevance to contemporary educational needs and to develop alternative approaches that might provide a more meaningful educational experience and, by doing so, alleviate the drop-out and truancy problems that are closely linked to substance abuse in this age group.

This should be a top priority concern of the Office of Education.

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o Community colleges need to develop courses and short-term training programs for women in such areas as parenting, survival skills, and problem solving.

The Office of Education should provide funds and technical assistance for the development of these courses.

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o A variety of training opportunities related to women's health and substance abuse problems are needed within each state, including:

a. the assurance of equal training opportunities for male and female personnel.

b. the provision of sensitivity training for all treatment program staff members.

b. the inclusion of private sector personnel in appropriate training programs.

d. the development of programs for police, probation, and parole officers and other within the criminal justice system.

e. the development of programs to assist business, industry and unions identify and help women with potential or actual substance abuse problems.

f. the use of physicians as peer educators on such topics as prescription drug abuse and the implications of substance abuse for infants and young children.

The provision of training opportunities should be a collaborative effort, with state agencies working closely with the private sector. At the Federal level, training is authorized in PL 93-415, Sections 241, 244 and 249-51, the Juvenile Justice Delinquency Prevention Act; for those working with prevention, treatment and control, in PL 94-63, Community Mental Health Center Amendments of 1975; for professional schools and health providers, the Comprehensive Employment and Training Act and the Domestic Voluntary Service Act.

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TREATMENT

In addition to the overall suggestions that drug abuse and alcohol treatment programs must address the specific needs of women, and that efforts must be made to assure that programs are attractive to women and do not covertly discourage women from seeking treatment or discriminate against them, Alliance participants made some very specific suggestions about the services and facilities that must be available to assist women with substance abuse problems.

o The following services must be available to women with substance abuse problems, either within treatment programs or through cooperative referral to appropriate agencies:

a. health care, with specific attention to gynecological problems, venereal disease, birth control and abortion.

b. health education.

c. education counseling.

d. vocational training and job placement.

e. child care.

f. sex education and sexuality counseling.

g. rape counseling.

h. marriage counseling.

i. parent skills training.

j. counseling for family members.

k. training to develop coping and survival skills.

l. legal assistance.

m. transportation.

The provision of these services should be specified in treatment guidelines and funding requirements of NIDA, NIAAA, and NIMH. Cooperative agreements between agencies to assure a full range of services should be a requirement for state Formula Grant eligibility. Authorization to provide many of these services for handicapped clients is found in the Rehabilitation Act of 1973, the Social Security Act, and the Comprehensive Employment and Training Act of 1974. Funds for parent skills training may be available under Title XX of the Social Security Act and through Head Start, since 300 of these programs now provide Home Start.

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o A variety of treatment approaches and facilities are needed for women with substance abuse problems, including:

a. halfway and quarterway houses.

b. long and short-term residential treatment centers.

c. emergency shelters.

d. outpatient treatment centers, preferably located within mental health or counseling facilities to provide anonymity.

e. "women only" programs.

f. treatment programs for women in prison.

g. treatment programs at places of employment.

h. mobile facilities for use in rural areas.

i. information, counseling, and referral telephone "hotlines."

j. pre-crisis programs.

Provision of these programs should be specified in relevant state plans. The LEAA/TASC pilot demonstration treatment and rehabilitation projects for addicted prisoners should be expanded to include more than one woman's prison. Appropriations authority may be found in PL 93-641 - National Health Planning and Resource Development; Titles IV(a), VI, XIX and XX of the Social Security Act; Sections II, IV, V and VI of PL 94-230, The Rehabilitation Act Extension of 1976; PL 93-203, the Comprehensive Employment and Training Act of 1973, among others. Assistance for isolated populations should be available through the Bureau of Community Health Services.

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o New treatment approaches are needed for women substance abusers. These should include projects designed to evaluate and answer such unresolved issues as:

a. the effectiveness of such techniques as assertiveness training, confrontation, self-help groups, psychotherapy, behavior therapy and drug therapy.

b. the effectiveness of separate treatment programs for women.

c. the validity of the idea that female staff members provide valuable role models and facilitate the rehabilitation process.

d. the relationship between the attitudes of program personnel towards women with substance abuse problems and the success of treatment.

e. the effectiveness of using paraprofessionals or peer groups in place of more conventional treatment.

Authorization for the types of projects proposed can be found in the amendments to the Drug and Alcohol Act, the Controlled Substances Act and the Community Mental Health Centers Act.

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o Under-utilized public health facilities, including medical services associated with teaching hospitals, need to be used to provide care for poly-drug and alcohol patients. This would:

a. meet the housing need for new "treatment slots."

b. provide a degree of problem-specific anonymity to make treatment more acceptable to women.

c. permit easier access to third party payments.

d. increase training and credentialing opportunities.

Regulations developed for PL 93-641, the National Health Planning and Resource Development Act, should be broad enough to permit communities to issue certificates of need for such purposes. Also, PL 94-581, the Veterans Omnibus Health Care Act of 1976, should be amended to permit similar use.

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o Community Mental Health Centers need to be actively involved in the provision of services to women with substance abuse problems.

Section 221 of PL 94-63, Community Mental Health Center Amendments, should be amended to require treatment for alcoholism and drug abuse except when a Community Mental Health Center has reached patient capacity. In addition, Section 204 of the same bill should be amended to increase "consultation and education" services.

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o Model uniform legislation is needed to eliminate the threat of permanent removal of minors from the care of drug or alcohol-dependent mothers who seek treatment, and to provide for the safety and temporary care of dependent children.

The Department of HEW should work with the Uniform State Law Commission of the American Bar Association to develop and encourage states to adopt such model uniform legislation. PL 93-415, the Juvenile Justice Delinquency Prevention Act of 1974, and Title XX of the Social Security Act should provide funds for temporary care.

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ADMINISTRATION

Participants made a number of suggestions for more effective administration and coordination of state programs intended to aid women.

o States need to review the application of affirmative action programs to assure that women and minority group members have equal opportunity in appointments to administrative positions. States also need to increase the number of women who serve as members of state and regional health planning advisory councils and to include among them women from rural and urban areas as well as women who belong to

different ethnic, cultural and socio-economic groups, and different age groups.

Federal funding agencies should require this review of staffing patterns and procedures, in report form, as a prerequisite for funding renewal. The regulations for the Health Resources and Development Act of 1974 should be more specific about requirements for consumer representation.

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o The Federal government needs to develop mechanisms to assure that the appropriate agencies within each state conduct needs assessments on women's substance abuse problems and establish formal service policies, with funds specifically earmarked for women.

Amendments to the Drug Abuse and Treatment Act should require the development of statutory relationships between state authorities and Federal funding agencies to assure that the intent of legislation such as PL 94-371 is actually being met.

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o A full-time coordinator for women's health and women's substance abuse problems is needed in each state, with responsibilities to include:

a. compiling and publishing a resource directory of treatment facilities (with program descriptions and eligibility requirements), medical and mental health facilities available to women, private groups, self-help groups and educational programs, as well as information on such relevant services as child care, transportation, vocational training, job placement, and referral.

b. serving as an advocate for women's issues among both the public and the private sector.

c. working with the school system within the state to review existing information and prevention materials to assure that the materials focus on the health needs of women.

d. identifying resources and working to develop the state-wide and community linkages that will enhance the provision of health services for women.

e. actively promoting the concept of comprehensive health services for women through efforts to integrate and coordinate existing health and social services.

f. establishing a task force to draw attention to women's needs (including member representatives of "at risk" population groups) and to review treatment plans and proposals.

g. working with mental health, correction and law enforcement agencies and with the divisions of alcohol and drugs to develop treatment programs for women in institutions.

PL 94-103, the Developmentally Disabled Assistance and Bill of Rights Act, sets precedent for assisting states in developing a full range of services, assuring rights to appropriate treatment, and including private sector representatives. The continuum of care described should provide a blueprint for state planning in provision of health care for women. Section 205 of PL 94-63, the Community Mental Health Center Amendments of 1975, provides "Conversion Grant" assistance to meet operating

deficits which may result from initiating new, more comprehensive services. These precedents, and other laws with similar intent combined with Sections 10(a)(1) and 10 (d) of PL 94-371 provide justification for this new position.

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A CONCLUDING PROPOSAL

While the work of the Alliance has ended, the progress already seen in many states and the widely expressed need for a continuation of efforts focusing on women's substance abuse issues raise a critical question:

How can the promise generated by this project be sustained?

The work of the Alliance was only a beginning, a necessary prologue to a larger and continuing effort. Women's substance abuse problems will not vanish merely because they have been identified, nor will they be quickly eased. They are firmly rooted in the social structure of this country; they affect the health of the nation.

Over the years, it has been the intent of Congress to address the health needs of the entire nation. Unfortunately, though, attempts to assure full health for all citizens have been piecemeal and fragmented, leading to the existing patchwork of services and programs that sometimes overlap but more typically leave great gaps.

As recently as 1976, Congress tried to address the specific problems of women substance abusers, giving priority to efforts to resolve these problems. The fragmentation that has hindered so many programs threatens these initiatives as well.

The problems of women substance abusers have a devastating societal impact. Their reverberations are felt in such related areas as family violence, juvenile delinquency, and

criminal behavior, as well as in the physical and mental health of women, their progeny, and others affected by their substance abuse problems.

Because of the far-reaching impact, a high level commission is needed to deal with the causes and implications of substance abuse among women.

This commission should work closely with the earlier proposed inter-departmental task force and should have among its members both public and private sector representatives whose interests cut across disciplines and systems.

The result of the commission's work should promise not only remedies for existing deficiencies in the law but should also promote sufficient public awareness to engender a more positive approach to preventing the continued acceleration of women's substance abuse problems.

It is therefore proposed that the Congress should enact a statute creating a Commission on the Causes and Implications of Substance Abuse Among Women and appropriate sufficient funds for its work.

The statute should carry a requirement that the Commission's findings and conclusions be reported to Congress and to the President for legislative action as may be determined to be needed as a result of these findings.

Alternatively, if the President chooses, he could create this Commission by Executive Order and support it through White House contingency funds. The findings would then remand to the President for his referral to Congress.